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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Insurance Division[191]

- Replace Analysis
- Replace Chapter 11
- Replace Chapter 20
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- Replace Chapter 72

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- Replace Chapter 251

Revenue Department[701]

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- Replace Chapter 40
- Replace Chapter 53

Replace Chapter 59
Remove Reserved Chapters 216 to 218
Insert Chapter 216 and Reserved Chapters 217 and 218
Replace Chapter 231

Transportation Department[761]

Replace Chapters 105 and 106

INSURANCE DIVISION[191]

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

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CHAPTER 11
CONTINUING EDUCATION FOR
INSURANCE PRODUCERS
[Prior to 10/22/86, Insurance Department[510]]

191—11.1(505,522B) Statutory authority—purpose—applicability.

11.1(1) These rules are adopted pursuant to the general rule-making authority of the commissioner in Iowa Code chapters 505 and 522B to establish continuing education requirements for resident and nonresident insurance producers.

11.1(2) The purpose of these rules is to establish requirements by prescribing:

- a. The minimum number of continuing education credits that an insurance producer must complete;
- b. The procedure and standards that the division will utilize in the approval of continuing education providers and courses;
- c. The procedure for establishing that the required continuing education has been completed; and
- d. Enforcement criteria and guidelines.

11.1(3) These rules do not apply to:

- a. A nonresident producer who resides in a state or district having a continuing education (CE) requirement for insurance producers.
- b. A resident producer who holds qualification in the surety or credit lines of authority.
- c. Licensed attorneys who are also producers who submit proof of completion of continuing legal education for the appropriate calendar years during the CE term and otherwise comply with the producer license renewal procedures set forth in 191—Chapter 10.
- d. A producer who serves full-time in the armed forces of the United States of America on active duty during a substantial part of the CE term and who submits evidence of such service.
- e. A resident producer who holds qualification only for a crop insurance line of authority and who complies with subrule 11.3(8).

[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.2(505,522B) Definitions. In addition to the definitions in rules 191—1.1(502,505) and 191—10.2(522B), the following definitions apply:

“*Approved subject*” or “*approved course*” means any educational presentation which has been approved by the division.

“*Attendance record*” means a record on which a CE provider requires attendees of a CE course to sign in at the time of entrance to the course.

“*CE*” means continuing education as referenced in Iowa Code chapter 522B.

“*CE provider*” means any individual or entity that is approved to offer continuing education courses in Iowa.

“*CE term*” means the period of time that begins either on the date when a new producer’s insurance license is issued or on the date after the expiration date of an existing producer’s license and that ends on the following license expiration date.

“*Credit*” means continuing education credit. One credit is 50 minutes of instruction or reading material in an acceptable topic.

“*Proctored*” or “*independently proctored*” means the supervision by a CE provider or disinterested third party over the conduct of a producer while that producer is completing an examination that is part of a self-study CE course.

“*Roster*” means a listing of all licensed attendees at an approved course and includes the Iowa course number, the National Insurance Producer Registry (NIPR) National Producer Number (NPN), the date the course was completed, and the actual number of credits earned by each producer.

“*Self-study course*” means an educational program that consists of a self-study manual and comprehensive examination. A self-study course may be an online course.

[ARC 7662B, IAB 3/25/09, effective 4/29/09; ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.3(505,522B) Continuing education requirements for producers.

11.3(1) Every licensed resident producer must complete a minimum of 36 credits for each CE term in courses approved by the division. Three of these credits must be in the subject of ethics. By the end of the last business day of the producer's CE term, the division must receive from the producer proof of completion of the CE courses.

11.3(2) An instructor of an approved subject is entitled to the same credit as a student completing that subject and may receive such credit once during a CE term.

11.3(3) A producer cannot carry over CE credits earned in excess of the producer's CE term requirements from one CE term to the next.

11.3(4) A producer may receive CE credit for self-study courses. A self-study course is considered completed when the examination is received by the CE provider.

a. A producer may receive CE credit for self-study courses that are part of a recognized national designation program as described in subrule 11.5(5).

b. A producer may receive CE credits for self-study courses during a CE term that do not meet the definition of paragraph 11.3(4) "a" if the producer:

(1) Submits an affidavit to the CE provider stating that the examination was independently proctored and was completed without any outside assistance, and

(2) Correctly answers at least 70 percent of the questions presented.

11.3(5) A producer may not receive CE credit for courses taken prior to the issuance of an initial license.

11.3(6) A producer cannot receive CE credit for the same course twice in one CE term. A producer cannot receive CE credit both for the classroom portion and for the examination portion of a national designation program as defined in subrule 11.5(5).

11.3(7) A producer may elect to comply with the CE requirements by taking and passing the appropriate licensing examination for each qualification held by the producer.

11.3(8) A resident producer who only holds qualification for a crop insurance line of authority needs only to demonstrate the following to renew:

a. The producer has completed all training and continuing education requirements imposed by the federal Risk Management Association, if any; and

b. The producer has completed 18 credits of continuing education, 3 of which must be in the area of ethics.

[ARC 4910C, IAB 2/12/20, effective 3/18/20; ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—11.4(505,522B) Proof of completion of continuing education requirements.

11.4(1) *Producer duties.*

a. Producers must demonstrate compliance with the CE requirements at the time of license renewal. Procedures for completing the license renewal process are outlined in 191—Chapter 10.

b. Producers must maintain a record of all CE courses completed by keeping the original certificates of completion for four years after the end of the year of attendance.

11.4(2) *Insurer duties regarding federal flood insurance.* An insurer authorized to do business in Iowa must demonstrate to the division, upon the division's request, that producers appointed by the insurer have complied with all continuing education guidelines as established by the National Flood Insurance Program (NFIP).

[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.5(505,522B) Course approval.

11.5(1) To qualify for approval a course must be designed to expand technical insurance skills and knowledge obtained prior to initial licensure or to develop new and relevant skills and knowledge.

11.5(2) Any approved active CE provider must submit a request for approval of any course, program of study, or subject for continuing education credit to the division on an NAIC uniform form. If an outside vendor is retained by the division for course reviews, requests for approval must be filed directly with the vendor.

11.5(3) Requests for course approval that do not include all required information will be returned as incomplete.

11.5(4) Except as provided in subrule 11.5(5), requests for approval must be submitted at least 30 days prior to the beginning of the course. A request for renewal of a previously approved course must be submitted at least 30 days prior to the end of the 24-month approval period. Requests received later may be disapproved.

11.5(5) A request for approval of any self-study course that is part of a recognized national designation program may be filed within 60 days after the course is completed. This course will be reviewed and may be approved for up to the number of credits awarded for passage of the national examination in topics that are otherwise approvable under these rules.

11.5(6) An insurance producer who attends a classroom course offered by a college, university or governmental agency that has not been approved by the division may make application for approval of the provider and course for CE credit. The application must be filed within 60 days of attendance at the course and must contain sufficient materials to allow for a thorough evaluation of the provider, course content, and instructor qualifications. To be eligible for CE credit, the course must meet all division guidelines for course approval. All course review fees must be paid by the producer.

11.5(7) A CE course must be offered for a minimum of one credit. Fractional credits will not be awarded. The total credit that may be awarded for a CE course is limited to 36 credits.

11.5(8) Notification will be sent to the CE provider indicating approval or disapproval. Approved courses will be assigned a course number.

11.5(9) The division may deem the approval of a CE course by another state's insurance division as adequate evidence that a course is eligible for approval in Iowa and may award the same number of credits for the course awarded by the other state. The CE provider must submit the NAIC uniform form demonstrating the other state's approval of the CE course.

11.5(10) Within 30 days of course approval, CE providers must inform the division or its vendor, as directed by the division, of the dates and locations that the course will be offered. Failure to timely file the dates and locations subjects the CE provider to penalty and suspension or rescission of course approval.

11.5(11) CE courses approved by the division may be offered for a 24-month period following the date of approval.

[ARC 4910C, IAB 2/12/20, effective 3/18/20; ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—11.6(505,522B) Topic guidelines.

11.6(1) The following course topics are examples of subjects that will qualify for approval:

1. Rating;
2. Tax laws (specifically related to insurance);
3. Policy contents;
4. Proper uses of products;
5. Ethics;
6. Risk management;
7. Iowa insurance laws and administrative rules;
8. Technical information related to the insurance license;
9. Errors and omissions;
10. Estate planning/taxation;
11. Wills and trusts; and
12. Financial planning.

11.6(2) The following course topics are examples of subjects that will not qualify for approval:

1. Sales;
2. Motivation;
3. Prospecting;
4. Psychology;
5. Communication skills;

6. Prelicense training;
7. Supportive office skills (e.g., typing, filing, computers);
8. Personnel management;
9. Recruiting; and
10. Other subjects not related to the insurance license.

191—11.7(505,522B) CE course renewal. Prior to expiration of the 24-month approval period, a CE provider must apply for renewal of each course with the division or its outside vendor. If a CE provider makes a substantial change to the content of a previously approved course, that course will not be eligible for renewal and must be submitted for a complete review.

191—11.8(505,522B) Appeals. A CE provider may appeal the amount of CE credit awarded by the division for a course. An appeal must be made in writing to the division within 30 days of the receipt by the CE provider of the notice of CE credit awarded for the course. If the division retains an outside vendor for course reviews, a CE provider must first complete an appeal process with the vendor before filing an appeal with the division.

191—11.9(505,522B) CE provider approval.

11.9(1) Any school, insurer, industry association or other organization intending to provide a course, program of study, or subject for continuing education credit must submit an application on a form or in a format prescribed by the division to become an approved CE provider.

11.9(2) To qualify for approval, a CE provider must demonstrate financial and organizational stability and must agree to comply with the administrative and regulatory constraints set forth by the division.

11.9(3) CE provider approval is valid for 24 months.

11.9(4) A CE provider must complete the renewal process to be eligible to continue serving as a CE provider. Failure to complete the renewal process will result in the expiration of the CE provider's approval and all previously approved courses.

11.9(5) If an outside vendor is retained by the division for CE provider reviews, requests for approval will be filed directly with the vendor.

191—11.10(505,522B) CE provider's responsibilities.

11.10(1) A CE provider must ensure that each classroom course is conducted by a qualified and competent instructor.

11.10(2) A CE provider must obtain and maintain an attendance record for each course for at least four years from the end of the year in which the course is offered. Upon request by the division, a CE provider must submit copies of attendance records.

11.10(3) A CE provider of an approved course is responsible for both the attendance of the students and their attention. A CE provider must refuse to award CE credit for time periods when the student was absent.

11.10(4) A CE provider must verify that each examination submitted for a self-study course contains an affidavit following the NAIC CE guidelines from the producer that the examination was independently proctored and that the examination was completed without any outside assistance. A CE provider must refuse to award CE credit to producers who fail to submit a properly completed examination or who fail to correctly answer at least 70 percent of the questions on the examination.

11.10(5) Upon request by the division, a CE provider must videotape a course and such recording must be promptly submitted to the division.

11.10(6) Upon request by the division, a CE provider must provide a copy of all course materials.

11.10(7) If an approved course is canceled, a CE provider must notify the division, or its outside vendor, and registrants at least 48 hours prior to the course date.

11.10(8) CE providers must submit rosters of all course attendees to the division's outside vendor. These reports must be received at the division by the tenth day of the month following the month in

which the course is completed. Rosters must be submitted electronically in a manner prescribed by the division.

11.10(9) Once a course is completed, the CE provider must issue a certificate of completion to each person who satisfactorily completes a course. The certificate must be issued within 20 days of course completion and must be signed by either the course instructor or the CE provider's authorized representative. The certificate of completion used by the CE provider must be in a form or format prescribed by the division.

11.10(10) CE providers must report to the division any disciplinary action taken against that CE provider by another state licensing authority.
[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.11(505,522B) Prohibited conduct—CE providers.

11.11(1) CE providers must not:

- a. Advertise, prior to approval, that a course is approved;
- b. Prepare and distribute certificates of completion before the course has been conducted;
- c. Issue inaccurate or incomplete certificates of completion;
- d. Refuse to issue certificates of completion to any participant who satisfactorily completes an approved course, except when subrule 11.10(3) or subrule 11.10(4) applies.

11.11(2) The division may revoke the approval of a continuing education provider or may discipline a continuing education provider, upon a finding that the CE provider:

- a. Committed any one or more of the actions prohibited in subrule 11.11(1);
- b. Failed to perform any duties required by these rules; or
- c. Committed any other action inconsistent with these rules.

11.11(3) If the division finds that a CE provider has violated Iowa laws or these rules, the division must give written notification to the CE provider of the alleged improper conduct and any discipline or sanction imposed. The CE provider may make a written request for a hearing within 30 days of receipt of the notice. The hearing must be held within 30 days of the division's receipt of the written demand by the CE provider unless the parties agree to a later hearing date. The hearing must be conducted pursuant to 191—Chapter 3.

11.11(4) A fine may be imposed against a CE provider if the commissioner finds, after hearing, that the CE provider knew or should have known that it was in violation of this chapter. The division may take any one or more of the following actions upon a finding of a violation of this rule:

- a. Require the CE provider to pay a fine not to exceed \$1,000 per violation;
- b. Require the CE provider to refund the course admission fee to all participants;
- c. Require the CE provider to provide a suitable course to replace the course that was found in violation;
- d. Withdraw the approval of courses sponsored by such CE provider; or
- e. Take other disciplinary action permitted by statute.

[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.12(505,522B) Outside vendor. The division may enter into a contractual arrangement with a qualified outside vendor to assist the division with any or all continuing education services.

[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—11.13(505,522B) CE course audits. The division may audit any CE course. The cost of the audit will be charged to the CE provider. Any discrepancies between the materials submitted for approval to the division and the content found at the audit, or any evidence of noncompliance with these rules, may subject the CE provider or instructor to administrative sanctions, including imposition of fines. Governmental bodies, such as community colleges and universities, shall not be charged for the cost of an audit.

191—11.14(505,522B) Fees and costs.

11.14(1) The fees for approval and renewal of CE providers, CE courses and registration of instructors shall be set by the outside vendor retained by the division and are subject to approval by the division. Course approval fees are nonrefundable.

11.14(2) The division may charge a fee for other services.
[ARC 4910C, IAB 2/12/20, effective 3/18/20]

These rules are intended to implement Iowa Code chapters 505 and 522B.

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PROPERTY AND CASUALTY INSURANCE

CHAPTER 20

PROPERTY AND CASUALTY INSURANCE

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

DIVISION I

FORM AND RATE REQUIREMENTS

191—20.1(505,509,514A,515,515A,515F) General requirements for filing rates and forms.

20.1(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Insurance companies must comply with the division's requirements for submissions, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set out on the SERFF website at serff.com.

20.1(2) No rate filing shall include any adjustment designed to recover underwriting or operating losses incurred out of state. Upon request by the commissioner, insurers doing business in Iowa shall segregate in their rate filings data from any state identified by the commissioner, and the filings shall include a certification that no portion of any rate increase is designed to recover underwriting or operating losses incurred in another state.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.2(505) Objection to form filing.

20.2(1) Any insured or established organization with one or more insureds among its members that has an objection to a form filing may submit to the insurance commissioner a written request for a hearing on the filing. A request for a hearing must be filed within 20 days after the filing has been received by the commissioner.

20.2(2) Within 20 days after receipt of the request for a hearing, the commissioner will hold a hearing to consider the objection to the filing. The commissioner will provide not less than 10 days' written notice of the time and place of the hearing to the person or association filing the request, to the filing insurer or organization, and to any other person requesting notice. The commissioner may suspend or postpone the effective date of the filing pending the hearing. Upon consideration of the information received at the hearing, the commissioner may determine whether or not to approve the filing.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.3(515,515A,515C,518,518A,520) Letter of transmittal. Rescinded IAB 10/25/06, effective 11/29/06.

191—20.4(505,509,514A,515,515A,515F) Policy form filing.

20.4(1) Each policy form, endorsement, application and agreement modifying the provisions of policies must bear an identification form number. This form number must be in the lower left-hand corner unless uniform or authentic forms are used.

20.4(2) Rescinded IAB 2/19/14, effective 3/26/14.

20.4(3) A form filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from the date that all necessary requirements are submitted to SERFF.

[ARC 1334C, IAB 2/19/14, effective 3/26/14; ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.5(515A) Rate or manual rule filing.

20.5(1) Every insurer shall determine and file its final rates with the commissioner pursuant to provisions of Iowa Code chapter 515F, except for insurers of workers' compensation who are specifically excluded by Iowa Code section 515F.3(2) and residual market mechanisms.

a. Advisory organizations, defined in Iowa Code section 515F.2 and licensed pursuant to Iowa Code section 515F.8, may file on behalf of their member and subscriber companies prospective loss costs,

supplementary rating information and supporting information as defined in Iowa Code section 515F.2. Advisory organization filings shall be filed and made effective in accordance with the provisions of Iowa Code sections 515F.4 to 515F.6 or 515F.23 to 515F.25 that apply to the filing and approval of rates and supplementary rating information.

b. An insurer may satisfy its obligation to make rate filings by becoming a participating insurer of a licensed advisory organization that makes reference filings of advisory prospective loss costs and by authorizing the commissioner to accept such filings on its behalf. The insurer's rates shall be the prospective loss costs filed by the advisory organization which have been put into effect in accordance with paragraph 20.5(1) "a," combined with the loss cost adjustments which are filed in accordance with paragraph 20.5(1) "a."

c. An insurer may satisfy its obligation to make filings of supplementary rating information by becoming a participating insurer of a licensed advisory organization that makes such filings and by authorizing the commissioner to accept such filings on its behalf, subject to any modifications filed by the insurer.

d. If an insurer has previously filed forms modifying coverage provided by the applicable advisory organization forms, such fact should be noted in the rate filing.

20.5(2) Rate filings shall reflect that due consideration has been given to the factors enumerated in Iowa Code section 515F.4(1), and shall be accompanied by supporting statistical exhibits. In addition, each filing shall note the date of the last revision of rates affecting this coverage and briefly describe the nature of that revision.

20.5(3) Insurers making filings on their own behalf and advisory organizations making a filing on behalf of an insurer shall identify each page filed by printing, typing or stamping their own name thereon.

20.5(4) If a company filing rates used the manuals of an advisory organization in its filings, any portion of the manuals of the advisory organization that will not be followed by the filing must be clearly shown as deleted or amended by use of an appropriately numbered exception page.

20.5(5) For residual market mechanisms, insurers making filings on their own behalf shall identify the submission as an independent filing or a deviation from the previously filed form, rate, or rule. A deviation filing is a submission which represents modification of a form or rate or rule previously filed by an authorized rating organization or advisory organization on behalf of its member and subscriber companies. If an insurer has previously filed forms modifying coverage provided by the applicable standard forms, such fact should be noted in the rate filing.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.6(515A) Exemption from rate filing requirement.

20.6(1) An insurer requesting, pursuant to Iowa Code section 515F.5(4), suspension or modification of the requirement of filing of a rate shall provide the commissioner with a full explanation for the proposed exemption from the filing requirement together with any actuarial data available and shall furnish the commissioner with any additional material the commissioner may desire.

20.6(2) If the commissioner finds that a proposed rate represents a classification for which credible and homogeneous statistical experience does not exist and cannot be analyzed using standard actuarial techniques to produce a statistically significant average rate for the individual risks within the classification, the commissioner may exempt the insurer from the filing requirement for that proposed rate.

20.6(3) An insurer shall maintain statistical records of the experience and expenses attendant upon the risks covered by any rate exempted by the commissioner from the filing requirement. The insurer may supplement statistical information filed with the commissioner with information by an advisory organization licensed pursuant to Iowa Code section 515F.8.

This rule is intended to implement Iowa Code section 515A.4(6).

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.7(515E) Risk retention and purchasing groups. Rescinded IAB 11/22/06, effective 12/27/06.

191—20.8(515F) Rate filings for crop-hail insurance. Rate filings for crop-hail insurance shall be submitted on or before January 31 of each calendar year. Each company may file one set of rates per policy plan per calendar year which shall remain in effect throughout the current crop year. In the absence of a new filing, rates on file from the previous year will remain in effect. Each filing shall be accompanied by a cover letter, synopsis sheet and supporting data which justify the filed rate.
[ARC 2227C, IAB 10/28/15, effective 12/2/15]

191—20.9(515F) Licensing advisory organization. Rescinded IAB 3/28/07, effective 5/2/07.

191—20.10(515F) Exemptions. Rescinded IAB 3/28/07, effective 5/2/07.

191—20.11(515) Exemption from form and rate filing requirements.

20.11(1) The following lines of insurance shall be exempt from the form filing requirements of Iowa Code section 515.102:

- a. Aircraft hull and aviation liability.
- b. Difference-in-conditions.
- c. Kidnap-ransom.
- d. Manuscript policies and endorsements issued to not more than two insureds in Iowa.
- e. Political risk.
- f. Reinsurance.
- g. Terrorism.
- h. War risk.
- i. Weather insurance.

20.11(2) Insurers shall be exempt from filing rates for the lines of insurance exempted in 20.11(1).

20.11(3) An insurer shall, within 30 days of the commissioner's request, provide the commissioner with any of the information which is exempted from form and rate filing requirements.

[ARC 1125C, IAB 10/16/13, effective 11/20/13; ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.12(515,515F) Use of credit history in underwriting and making of rates for personal automobile and homeowners policies. Rescinded IAB 11/24/04, effective 12/29/04.

191—20.13 to 20.40 Reserved.

These rules are intended to implement Iowa Code chapter 515F and Iowa Code section 515.109.

DIVISION II
IOWA FAIR PLAN ACT

191—20.41(515,515F) Purpose. This division is intended to implement and interpret Iowa Code sections 515F.30 to 515F.38 for the purpose of establishing procedures and requirements for a mandatory risk-sharing facility for basic property insurance coverage. This division is also intended to encourage improvement of and reasonable loss prevention measures for properties located in Iowa and to further orderly community development.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.42(515,515F) Scope. This division shall apply to all insurers licensed to write property insurance in Iowa.

191—20.43(515,515F) Definitions. In addition to the definitions of Iowa Code sections 514F.2 and 515F.32 and rule 191—20.1(505,509,514A,515,515A,515F), the following definitions apply:

“*Basic property insurance*” means insurance against direct loss to property as defined in the standard fire policy and extended coverage, vandalism, and malicious mischief endorsements; homeowners insurance; and such other coverage or classes of insurance as may be added to the FAIR Plan by the commissioner. Basic property insurance shall include:

1. Coverage provided in the customary fire policy and in the customary extended coverage and builders risk endorsements.

2. Coverage against loss or damage by burglary or theft, or both.

3. Coverage at least equivalent to that provided in a modified coverage form homeowners policy.

"Habitational risk" means:

1. Dwellings, permanent or seasonal, designed for occupancy by not more than four families or containing not more than four apartments.

2. Private outbuildings used in connection with any of the risks described in "1."

3. Trailer homes at a fixed location.

4. Household and personal property in risks described in "1" to "3."

5. Tenants' contents in dwellings or apartment houses.

"Iowa FAIR Plan Association" or *"the Plan"* means the nonprofit, unincorporated mandatory risk-sharing facility established and governed by Iowa Code sections 515F.30 through 515F.38 and this division to provide for basic property insurance.

"Location" means a single building and its contents, or contiguous buildings and their contents, under one ownership.

"Manufacturing risks" means those risks eligible to be written under the customary manufacturing business interruption policy forms approved by the commissioner. The following are not considered manufacturing risks:

1. Dry cleaning and laundering—Carpet, rug, furniture, or upholstery cleaning; diaper service or infants' apparel laundries; dry cleaning; laundries; linen supply.

2. Installation, servicing and repair—Electrical equipment; electronic equipment; glazing; household furnishings and appliances; office machines; plumbing, heating and air conditioning; protective systems for premises, vaults and safes.

3. Laboratories—Blood banks; dental laboratories; medical or X-ray laboratories.

4. Duplicating or similar services—Blueprinting and photocopying services; bookbinding; electrotyping; engraving; letter service (mailing or addressing companies); linotype or hand composition; lithographing; photo engraving; photo finishing; photographers (commercial).

5. Warehousing—Cold storage (locker establishments); cold storage warehouse; furniture or general merchandise warehouse.

6. Miscellaneous—Barber shops; beauty parlors; cemeteries; dog kennels; electroplating; equipment rental (not contractors' equipment); film and tape rental; funeral directors; galvanizing, tinning, detinning; radio broadcasting, commercial wireless and television broadcasting; taxidermists; telephone or telegraph companies; textiles (bleaching, dyeing, mercerizing or finishing of property of others); veterinarians and veterinary hospitals.

"Motor vehicles" means vehicles which are self-propelled.

"Weighted premiums written" means:

1. Gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to property in this state excluding premiums on risks insured under the Plan, for basic property insurance, for homeowners multiple peril policies, for farm dwelling policies and for the basic property insurance premium components of all other multiple peril policies.

2. In addition, 100 percent of the premiums obtained for homeowners multiple peril policies shall be added to 100 percent of the premiums obtained for basic property insurance and the basic property insurance premium components of all other multiple peril policies. The basic year for the computation shall be the first preceding calendar year.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.44(515,515F) Eligible risks.

20.44(1) All risks at a fixed location shall be eligible for inspection and considered for insurance under the Plan except motor vehicles, inland marine risks, and manufacturing risks as defined above.

20.44(2) The maximum limits of coverage for the type of basic property insurance for customary fire and extended coverage which may be placed under the Plan are those established by the governing committee from time to time.

20.44(3) The maximum limits of coverage for the type of basic property insurance for burglary and theft which may be placed under the Plan are those established by the governing committee from time to time.

20.44(4) The maximum limits of coverage for the type of basic property insurance for homeowners coverage which may be placed under the Plan are those established by the governing committee from time to time.

191—20.45(515,515F) Membership.

20.45(1) Every insurer licensed to write one or more components of basic property insurance shall be considered a member of the Plan. Any other insurer may, upon application to and approval by the governing committee, become a member.

20.45(2) An insurer's membership terminates when the insurer is no longer authorized to write basic property insurance in Iowa, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(3) Any voluntary insurer member may terminate its membership only as of the last day of the fiscal year of the Plan by giving written notice to the Plan 30 days prior to the last day of the fiscal year of the Plan. The governing committee upon a majority vote may terminate the membership of a voluntary insurer. Any such terminated member shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(4) Subject to the approval of the commissioner, the governing committee may charge a reasonable annual membership fee.

191—20.46(515,515F) Administration.

20.46(1) The Plan shall be administered by the governing committee, subject to supervision of the commissioner, and operated by a manager appointed by the governing committee.

20.46(2) The governing committee shall consist of seven members, each of whom shall serve for a period of one year or until a successor is elected or designated. Each member shall have one vote.

191—20.47(515,515F) Duties of the governing committee.

20.47(1) The governing committee shall meet as often as may be required to perform the general duties of the administration of the Plan, or on the call of the commissioner. Four members of the committee present or by proxy shall constitute a quorum. Members of the committee who choose to appoint a proxy shall give a written proxy to the person elected to act as proxy. The written proxy shall then be filed with the governing committee, thus ensuring the validity of the proxy's actions as the governing committee performs its duties.

20.47(2) The governing committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds, and perform all other duties of the Plan. The adoption of or substantive changes in pension plans or employee benefit programs for the manager and staff shall be subject to approval of the governing committee.

20.47(3) The governing committee may designate an independent inspection firm to make inspections as required under the Plan and to perform such other duties as may be authorized by the governing committee.

20.47(4) The manager shall annually prepare an operating budget which shall be subject to approval of the governing committee.

20.47(5) The governing committee shall submit to the commissioner periodic reports setting forth information as the commissioner may request. On or before April 1 of each year, the governing committee shall submit a report summarizing any new programs or reforms in operation undertaken during the preceding calendar year in order to comply with any new legislation, regulations or directives

affecting the Plan. This report shall contain a statistical tabulation on business written in accordance with the Plan.

20.47(6) The governing committee shall separately code all policies written by the Plan so that appropriate records may be compiled for purposes of performing loss prevention and other studies of the operation of the Plan.

20.47(7) The governing committee shall authorize the manager to file rates, surcharge schedules and forms for prior approval by the commissioner.

20.47(8) The governing committee shall prepare such agreements and contracts as may be necessary for the execution of this division consistent with its provisions.

[ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.48(515,515F) Annual and special meetings.

20.48(1) There shall be an annual meeting of the insurers on a date fixed by the governing committee at which time members may be chosen.

20.48(2) A special meeting shall be called by the governing committee within 40 days after receipt of written request from any ten insurers, not more than one of which may be in a group under the same management or ownership.

20.48(3) The time and place of all meetings shall be reasonable. Twenty days' notice of an annual or special meeting shall be given in writing by the governing committee to all insurers defined above. Four members present in person or by proxy shall constitute a quorum. Voting by proxy shall be permitted.

20.48(4) Any matter not inconsistent with the law or this division may be proposed and voted upon at any special meeting of the committee. Notice of any such proposal shall be mailed to each insurer not less than 20 days prior to the final date fixed by the committee for voting thereon.

191—20.49(515,515F) Application for insurance.

20.49(1) Any person who has an insurable interest in an eligible risk in property permitted to be written in the Plan and who has received within the last six months a notice of rejection, nonrenewal or cancellation from an insurer may apply for insurance by the Plan.

20.49(2) An inspection need not be made if the governing committee determines that insurance can be provided for specified classes of risks on the basis of representations of the applicant or insurance producer.

20.49(3) The Plan may bind coverage. The Plan may wait until receipt of the inspection report or receipt of additional underwriting information before determining whether to bind coverage. Coverage will be bound by the Plan by acknowledgement to the producer.

191—20.50(515,515F) Inspection procedure.

20.50(1) The inspection by the Plan shall be without cost to the applicant.

20.50(2) The manner and scope of the inspection shall be prescribed by the Plan with the approval of the commissioner.

20.50(3) An inspection report shall be made for each property inspected covering pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. Representative photographs may be taken during the inspection to indicate the pertinent features of building, construction, maintenance, occupancy, and surrounding property.

20.50(4) After the inspection, a copy of the completed inspection report and any relevant photographs shall be kept on file by the Plan. The report shall include a description of any deficient physical condition changes proposed by the inspector. A copy of the inspection report shall be made available to the applicant or producer upon request.

191—20.51(515,515F) Procedure after inspection and receipt of application.

20.51(1) After receipt of the application, the inspection report, and any additional underwriting information requested from the applicant, the Plan shall within five business days complete and send to the applicant an action report advising the applicant of one of the following:

a. That the risk is acceptable. If the inspection reveals substandard conditions, appropriate charges may be imposed, but the report shall specify the improvements necessary for removal of each such charge.

b. That the risk is declined unless reasonable improvements noted in the action report are made by the applicant and confirmed by reinspection.

c. That the risk is declined because it fails to meet reasonable underwriting standards as set forth in 191—20.52(515,515F). Reasonable underwriting standards as set forth in 191—20.52(515,515F) shall not include neighborhood or area location or any environment hazard beyond the control of the property owner.

20.51(2) If the risk is accepted, the action report shall advise the applicant of:

a. The amount of coverage the Plan agrees to write.

b. The amount of coverage the Plan agrees to write if specified improvements are made.

c. The amount of coverage the Plan agrees to write only if a large or special deductible is agreed to by the applicant.

20.51(3) If the risk is accepted, the Plan, upon receipt of the premium, shall deliver the policy to the applicant or to the licensed producer designated by the applicant for delivery to the applicant. The Plan shall remit the commissions to the licensed producer designated by the applicant.

191—20.52(515,515F) Reasonable underwriting standards for property coverage.

20.52(1) The following characteristics may be used in determining whether a risk is acceptable for property coverage. Where there is more than one cause for declination, all causes shall be listed and complied with before the property may be accepted for insurance purposes.

a. Physical condition of property; however, the mere fact that a property does not satisfy all current building code specifications will not, of itself, suffice as a reason for declination.

b. The property's present use as extended vacancy or extended unoccupancy of the property for 60 consecutive days. Properties that are vacant or unoccupied for more than 60 days may be insured while rehabilitation or reconstruction work is actively in process, meaning that the insured or owner should make monthly progress in order to complete the rehabilitation or reconstruction within a one-year time frame.

c. Other specific characteristics of ownership, condition, occupancy or maintenance that violate the law and that result in substantial increased exposure to loss. Any circumstance considered under this paragraph must relate to the peril insured against.

d. Physical condition of buildings which results in an outstanding order to vacate, in an outstanding demolition order or in being declared unsafe in accordance with the applicable law.

e. One or more of the conditions for nonrenewal as listed in 191—20.54(515,515F) currently exist. The Plan shall upon notice that conditions at the buildings have changed consider new application for coverage.

f. Vandalism and malicious mischief coverage shall not be provided for a dwelling or commercial property where the property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least \$500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period.

g. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

h. Any other guidelines which have been approved by the commissioner.

20.52(2) Reserved.

[ARC 8624B, IAB 3/24/10, effective 4/28/10]

191—20.53(515,515F) Reasonable underwriting standards for liability coverage.

20.53(1) The following characteristics may be used in determining whether a risk is acceptable for liability insurance on homeowner policies:

a. Broken, cracked, uneven or otherwise faulty steps, porches, decks, sidewalks, patios and similar areas.

- b.* Downspouts or drains which discharge onto sidewalks or driveways.
- c.* Unsafe conditions including inadequate lighting of stairways.
- d.* Animals known to be vicious or animals that have caused a liability claim.
- e.* Swimming pools or private ponds not fenced in accordance with local regulations.
- f.* Unsafe, or the absence of, handrails.
- g.* Junk cars, empty refrigerators, trampolines or other potentially dangerous objects in the yard which are an attraction to children.
- h.* Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.
- i.* Any other guidelines which have been approved by the commissioner.

20.53(2) Liability insurance shall only be provided as contained in the Iowa FAIR Plan homeowners policy.

20.53(3) Liability insurance shall not be provided for risks with any of the deficiencies set forth in paragraphs 20.53(1) “a” through “g,” as disclosed by the application or inspection, until the deficiencies have been corrected.

20.53(4) Liability insurance may not be provided where there is a business operating at the insured location, unless the applicant has in force a business liability policy with limits of at least \$100,000 per occurrence providing premises liability coverage.

20.53(5) Liability insurance shall not be provided where the applicant owns three or more horses or other riding animals, unless the applicant has in force a liability policy with limits of at least \$100,000 per occurrence providing coverage for the ownership and use of the horses or other riding animals.

191—20.54(515,515F) Cancellation; nonrenewal and limitations; review of eligibility.

20.54(1) The Plan shall not cancel or refuse to renew a policy issued by the Plan except for the following reasons:

- a.* Facts as confirmed by inspection or investigation which would have been grounds for nonacceptance of the risk by the Plan had they been known to the Plan at the time of acceptance.
- b.* Changes in the physical condition of the property or other changed conditions as confirmed by inspection or investigation that make the risk uninsurable pursuant to paragraphs “j” and “k.”
- c.* Nonpayment of premiums.
- d.* At least 65 percent of the rental units in the building are unoccupied, and the insured has not received prior approval from the Plan of a rehabilitation program which necessitates a high degree of unoccupancy.
- e.* Unrepaired damage exists and the insured has stated that repairs will not be made, or such time has elapsed as clearly indicates that the damage will not be repaired. The elapsed time under this paragraph is a length of time over 60 days where the damage remains unrepaired, unless there are known to be extenuating circumstances.
- f.* After a loss, permanent repairs have not been commenced within 60 days following payment of the claim, unless there are known to be extenuating circumstances. The 60-day period starts upon acceptance of payment of the claim.
- g.* Property has been abandoned for 90 days or more.
- h.* There is good cause to believe, based on reliable information, that the building will be burned for the purpose of collecting the insurance on the property. The removal of damaged salvageable items, such as normally permanent fixtures, from the building shall be considered under this paragraph when the insured can provide no reasonable explanation for such removal.
- i.* A named insured or loss payee or other person having a financial interest in the property being convicted of the crime of arson or a crime involving a purpose to defraud an insurance company. The fact that an appeal has been entered shall not negate the use of this paragraph.
- j.* The property has been subject to more than two losses, each loss amounting to at least \$500 or 1 percent of the insurance in force, whichever is greater, in the immediately preceding 12-month period, or more than three such losses in the immediately preceding 24-month period, provided that the cause

of such losses is due to the conditions which are the responsibility of the owner named insured or due to the actions of any person defined as an insured under the policy.

k. Theft frequency in which there have been more than two thefts, each loss amounting to at least \$500, in a 12-month period.

l. Material misrepresentation in any statement to the Plan.

m. On homeowners policies, excessive theft or liability losses. If a given property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least \$500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period, the Plan may convert the homeowners policy to a dwelling policy without vandalism and malicious mischief coverage.

20.54(2) The Plan shall terminate all insurance contracts in accordance with Iowa Code sections 515.125, 515.127, and 515.128.

20.54(3) At the completion of 36 months of coverage and prior to the completion of 48 months, each risk shall be reviewed for its eligibility for coverage in the voluntary market. The risk shall be submitted by the Plan to the producer of record, if any, for a search of the voluntary market. If the producer resubmits the risk to the Plan, the risk must be resubmitted with a new application and a written statement from the producer that a search of the voluntary market was performed.

[ARC 8624B, IAB 3/24/10, effective 4/28/10]

191—20.55(515,515F) Assessments.

20.55(1) Participation and assessments by and upon each insurer in the Plan for losses and expenses in connection with Plan business shall be levied and assessed by the governing committee of the Plan on the basis of participation factors determined annually, giving effect to the proportion which such insurer's weighted premiums written bears to the aggregate weighted premiums written by all insurers in the Plan.

20.55(2) De minimis assessments. Any assessment of less than \$20 shall not be billed to an insurer, but will be accumulated as a deferred assessment until the cumulative amount deferred is at least \$20.

20.55(3) Late payment fee. Assessments shall be due and payable when billed. If any member fails to pay an assessment within 60 days after it is due, the insurer shall pay interest from the billing date at the rate of 1.5 percent per month. In the event that an insurer fails to pay any applicable late payment fee with an assessment, the amount of such unpaid late payment fee will be included in the amount of the insurer's next assessment.

20.55(4) Credits for voluntary writings. The Plan may develop a voluntary writing credit policy, subject to approval by the commissioner. Credits may be used as offsets to member company assessments made by the Plan.

191—20.56(515,515F) Commission.

20.56(1) Commission to the licensed producer designated by the applicant shall be 10 percent of all policy premiums. The Plan shall not license or appoint producers.

20.56(2) In the event of cancellation of a policy, or if an endorsement is issued which requires the premium to be returned to the insured, the producer shall refund proportionally to the Plan commissions on the return premium at the same rate at which such commissions were originally paid.

191—20.57(515,515F) Public education. In cooperation with the insurance commissioner, the Plan shall undertake a continuing education program with insurers, producers and consumers about the Plan's insurance program and its availability. All insurers and producers shall cooperate fully in the continuing education program. Such continuing education program will include the publication and distribution of literature:

1. Describing the Plan and its general operation;
2. Explaining the possible cost savings of obtaining insurance in the voluntary market; and
3. Advising of the availability of rate comparison charts.

191—20.58(515,515F) Cooperation and authority of producers.

20.58(1) Each insurer shall require its licensed producers to cooperate fully in the accomplishment of the intents and purposes of the Plan.

20.58(2) Licensed insurance producers shall not act as agents for the Plan.

20.58(3) Licensed insurance producers shall not do any of the following:

- a. Bind coverage for the Plan.
- b. Alter or change policies issued by the Plan.
- c. Settle losses of the Plan.
- d. Act on behalf of the Plan or commit the Plan to any course of action.

20.58(4) Licensed insurance producers shall assist applicants who need to apply for coverage under the Plan, and shall submit applications that meet the requirements under rule 191—20.49(515,515F). Producers shall follow the rules and procedures of the Plan.

191—20.59(515,515F) Review by commissioner. The governing committee shall report to the commissioner the name of any insurer or producer which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the governing committee or to pay within 30 days any assessment levied.

191—20.60(515,515F) Indemnification. Each person serving on the governing committee or any of its subcommittees, each member of the Plan, and the manager and each officer and employee of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by that person in connection with the defense of any action, suit, or proceeding in which that person is made a party by reason of that person's being or having been a member of the governing committee or a member or manager or officer or employee of the Plan, except in relation to matters as to which that person has been judged in an action, suit, or proceeding to be liable by reason of willful misconduct in the performance of that person's duties as a member of the governing committee or as a member, manager, officer or employee of the Plan. This indemnification shall not apply to any loss, cost or expense on insurance policy claims under the Plan. Indemnification under this rule shall not be exclusive of other rights to which the member, manager, officer, or employee may be entitled as a matter of law.

191—20.61 to 20.69 Reserved.

These rules are intended to implement 2003 Iowa Acts, chapter 119.

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

191—20.70(515) Purpose. The purpose of division III is to clarify what information an insurance company regulated by the division may provide its customer in connection with a commercial real estate transaction between the customer and a lender.

[ARC 0133C, IAB 5/30/12, effective 5/9/12]

191—20.71(515) Definitions. For purposes of division III, the following definitions shall apply:

“*ACORD*” means the Association for Cooperative Operations Research and Development.

“*Commercial real estate transaction*” means a non-recourse commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan and neither the borrower nor any of its members, partners, or shareholders, nor any related person to any of the aforementioned persons, bears the economic risk of loss in the event of a payment default under the terms of the lending transaction.

“*Division*” means the insurance division.

“*ISO*” means the Insurance Services Office, Inc.

[ARC 0133C, IAB 5/30/12, effective 5/9/12; ARC 5602C, IAB 5/5/21, effective 6/9/21]

191—20.72(515) Evidence of insurance.

20.72(1) Prior to the issuance of an insurance policy by an insurer, an insured who has entered into a commercial real estate transaction may request that the relevant insurer or a producer acting on behalf of the insurer provide the following items as evidence of insurance:

- a. An ACORD Form 75, a successor ACORD form, an ISO binder form, or a substantially similar binder form approved by the division; and
- b. An ACORD Form 28, a successor ACORD form, an ISO certificate form, or a substantially similar certificate of insurance form approved by the division.

The insurer or the producer acting on behalf of an insurer has the sole discretion to determine which division-approved binder form or certificate of insurance form the insurer or producer uses to comply with this rule.

20.72(2) An insurer or a producer acting on behalf of an insurer shall comply with a request made pursuant to this rule within 20 business days of the receipt of the request. The requirements of this rule shall not apply to an insurance producer who:

- a. Is unauthorized to provide the documents described in this rule; and
- b. Informs the insured of this fact within 20 business days of the receipt of the request.

20.72(3) Delivery of a binder along with a certificate of insurance requested pursuant to this rule may be accomplished by regular mail, overnight delivery, facsimile, physical delivery, electronic means, or other appropriate means.

20.72(4) Notwithstanding any language on a form provided pursuant to subrule 20.72(1) which language states that the form is for “information only,” a binder together with a certificate of insurance delivered pursuant to this rule shall be valid and may be relied upon by the borrower or by the borrower’s lender as evidence of insurance, including in any private civil action or administrative proceeding, until the delivery of the insurance policy to the borrower or the cancellation of the binder pursuant to Iowa Code sections 515.125 to 515.127.

20.72(5) An insurer or producer acting on behalf of an insurer that produces or delivers a binder and certificate of insurance to its customer pursuant to this rule may charge a reasonable fee for the production and delivery of the documents.

20.72(6) All insurers and all producers subject to this rule shall comply with the terms hereof within 90 days from May 9, 2012.

[ARC 0133C, IAB 5/30/12, effective 5/9/12]

These rules are intended to implement 2011 Iowa Code Supplement chapter 515.

191—20.73 to 20.79 Reserved.

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

191—20.80(505B,515,515D,518,518A,519) Notice of cancellation, nonrenewal or termination of property and casualty insurance.

20.80(1) Purpose and definitions.

a. *Purpose.* The purpose of this rule is to implement the policyholder protections of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B by clarifying the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer.

b. *Definitions.* As used in Iowa Code section 505B.1 and this rule:

“*Commissioner*” means the Iowa insurance commissioner or insurance division.

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;
2. Notice of an insurance company’s decision or intention not to renew a policy; and
3. For purposes of notices required by Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8, “notice of

cancellation, nonrenewal or termination” includes but is not limited to an insurance company’s notice of cancellation, forfeiture, suspension, exclusion, nonrenewal, intention not to renew, or failure to renew.

20.80(2) Scope. This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508, 515, 518, and 518A.

20.80(3) Delivery. For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

20.80(4) Electronic transmissions. Notwithstanding the requirements of subrule 20.80(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B.

This rule is intended to implement Iowa Code chapter 505B.

[ARC 1999C, IAB 5/27/15, effective 7/1/15; ARC 2415C, IAB 2/17/16, effective 3/23/16]

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¹ See IAB Insurance Division

CHAPTER 39
LONG-TERM CARE INSURANCE

DIVISION I
GENERAL PROVISIONS

191—39.1(514G) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514G, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

191—39.2(514G) Authority. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code section 514G.105 in accordance with the procedures set forth in Iowa Code chapter 17A.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.3(514G) Applicability and scope. Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies and long-term care coverage arrangements delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

191—39.4(514G) Definitions. For the purpose of these rules, the terms “*Group long-term care insurance*,” “*Commissioner*,” “*Applicant*,” “*Policy*,” “*Preexisting condition*” and “*Certificate*” shall have the meanings set forth in Iowa Code chapter 514G, “Long-Term Care Insurance Act.”

“*Long-term care insurance*” means an insurance policy, insurance contract, insurance certificate, or rider, which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital. This definition also encompasses group and individual annuities and life insurance policies or riders that provide directly for or supplement long-term care insurance as well as a policy or rider providing for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare Supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset-protection coverage, or accident-only coverage, specific disease or specified accident coverage, or limited benefit health coverage. The definition does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor eligibility for those benefits is conditional upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of 191—Chapter 39.

“*Long-term care coverage arrangement*” is a promise that long-term care will be delivered to a person upon need and the meeting of certain contractual requirements. The arrangement is offered to the general public or a sector of the general public at a cost determined by the use of sound actuarial principles based upon the probability of use. This definition does not include self-insurance.

“*Qualified long-term care insurance contract*” or “*federally tax-qualified long-term care insurance contract*” means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed;

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986.

“*Qualified long-term care insurance contract*” or “*federally tax-qualified long-term care insurance contract*” also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986.

191—39.5(514G) Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

39.5(1) “*Medicare*” shall be defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

39.5(2) “*Mental or nervous disorder*” shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

39.5(3) *Nursing care.*

a. “*Skilled nursing care*” shall not be defined more restrictively than one or more professional services performed for the benefit of the insured on a daily basis, by or under the supervision of a registered nurse, prescribed by a physician, appropriate and consistent with the diagnosis and conditions requiring care.

b. “*Intermediate nursing care*” shall not be defined more restrictively than care which meets all of the above when professional nursing services are delivered on a regular basis but less often than daily.

c. “*Custodial nursing care*” shall not be defined more restrictively than that level of care required to assist an individual in activities of daily living when, due to age complicated by sickness or injury, such care is required. This level of care can be performed by persons without professional skills or training.

39.5(4) “*Nursing facility*” shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law; be appropriately licensed or certified;

(2) Be primarily engaged in providing, in addition to room and board accommodations, skilled or intermediate nursing care under the supervision of a duly licensed physician;

(3) Provide nursing service by or under the supervision of a registered nurse (R.N.); and

(4) Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not include:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

39.5(5) “*Acute condition*” means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual’s health status.

39.5(6) “*Home health care services*” means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

39.5(7) “*Activities of daily living*” means at least bathing, continence, dressing, eating, toileting and transferring.

39.5(8) “*Adult day care*” means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

39.5(9) “*Bathing*” means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

39.5(10) “*Cognitive impairment*” means a deficiency in a person’s short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

39.5(11) “*Continence*” means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

39.5(12) “*Dressing*” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

39.5(13) “*Eating*” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

39.5(14) “*Exceptional increase*” means only those increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in rule 191—39.28(514G), exceptional increases are subject to the same requirements as other premium rate schedule increases.

The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

39.5(15) “*Hands-on assistance*” means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

39.5(16) “*Incidental,*” as used in subrule 39.28(10), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

39.5(17) “*Personal care*” means the provision of hands-on services to assist an individual with activities of daily living.

39.5(18) “*Qualified actuary*” means a member in good standing of the American Academy of Actuaries.

39.5(19) “*Similar policy forms*” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition of group long-term care insurance in Iowa Code section 514G.103 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

39.5(20) “*Toileting*” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

39.5(21) “*Transferring*” means moving into or out of a bed, chair or wheelchair.
[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.6(514G) Policy practices and provisions.

39.6(1) Renewability. The terms “*guaranteed renewable*” and “*noncancellable*” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of this chapter. No such policy issued to an individual shall contain renewal provisions other than “*guaranteed renewable*” or “*noncancellable*.”

a. The term “*guaranteed renewable*” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew. Rates may be revised by the insurer on a class basis.

b. The term “*noncancellable*” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

c. Notwithstanding the provisions in 191—subrule 36.5(4), long-term care insurance policies may contain a return of premium or cash value benefit so long as:

- (1) The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and
- (2) The insurer demonstrates in its filings that the reserve basis for the policies is adequate.

Any advertisement or sales presentation of a long-term care insurance policy with a return of premium or cash value benefit provision shall include a side-by-side comparison of premiums for the same policy with and without the return of premium or cash value benefit provision.

d. The term “*level premium*” may be used only when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subrule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.

39.6(2) Limitations and exclusions.

a. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

- (1) Preexisting conditions or disease;
- (2) Mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer’s disease or similar forms of irreversible dementia nor limit coverage for Alzheimer’s disease to the skilled or intermediate level of care);
- (3) Alcoholism and drug addiction;
- (4) Illness, treatment or medical condition arising out of:
 1. War or act of war (whether declared or undeclared);
 2. Participation in a felony, riot or insurrection;
 3. Service in the armed forces or units auxiliary thereto;
 4. Attempted suicide (sane or insane) or intentional self-inflicted injury;

5. Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

Paragraph "a" is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

b. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Iowa Code section 514G.105(3) "b" expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Iowa Code section 514G.105(3) "b."

c. No long-term care insurance policy may be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

39.6(3) Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

39.6(4) Continuation or conversion.

a. Group long-term care insurance issued in this state on or after January 1, 1992, shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this rule, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

c. For the purposes of this rule, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this rule, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as

to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than 31 days after termination, by group coverage, effective on the day following termination of coverage, that provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage, and for which the premium is calculated in a manner consistent with the requirements of paragraph "*f*" of this subrule.

h. Notwithstanding any other provision of this rule, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this rule, any insured individual whose eligibility for long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purpose of this rule: a "*Managed-Care Plan*" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

39.6(5) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

39.6(6) *Premiums.*

a. The premiums charged to an insured for long-term care insurance shall not increase due to either:

(1) The increasing age of the insured at ages beyond 65; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under subrule 39.29(6), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under subrule 39.29(6), the initial annual premium shall be based on the reduced benefits.

39.6(7) *Electronic enrollment for group policies.* In the case of group long-term care insurance, any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information is maintained.

The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.7(514G) Required disclosure provisions.

39.7(1) *Renewability.*

a. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

b. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

39.7(2) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, no riders or endorsements may be added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

39.7(3) *Payment of benefits.* A long-term care insurance policy which provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

39.7(4) *Limitations.* If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

39.7(5) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in Iowa Code section 514G.105(3) “*b*,” shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.”

39.7(6) *Disclosure of tax consequences.* With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these

accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subrule shall not apply to qualified long-term care insurance contracts.

39.7(7) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too shall be specified.

39.7(8) *Qualified long-term care contracts.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

39.7(9) *Nonqualified long-term care contracts.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.8(514G) Prohibition against postclaims underwriting.

39.8(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

39.8(2) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

39.8(3) Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

39.8(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate.

39.8(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners, substantially similar to Appendix A.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.9(514D,514G) Minimum standards for home health care benefits in long-term care insurance policies.

39.9(1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

- a.* By requiring that the insured/claimant would need skilled care in a nursing facility if home health care services were not provided;
- b.* By requiring that the insured/claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;
- c.* By limiting eligible services to services provided by registered nurses or licensed practical nurses;
- d.* By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the provider's licensure or certification;
- e.* By requiring that the insured/claimant have an acute condition before home health care services are covered;
- f.* By limiting benefits to services provided by Medicare-certified agencies or providers;
- g.* By excluding coverage for personal care services provided by a home health aide;
- h.* By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
- i.* By excluding coverage for adult day care services.

39.9(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.10(514D,514G) Requirement to offer inflation protection.

39.10(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offers, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

- a.* Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;
- b.* Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
- c.* Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

39.10(2) Where the policy is issued to a group, the required offer in subrule 39.10(1) shall be made to the group policyholder; except, if the policy is issued to a group defined in Iowa Code section 514G.103(9)“*d*,” other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

39.10(3) The offer in subrule 39.10(1) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

39.10(4) Insurers shall include the following information in or with the outline of coverage:

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of

the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

39.10(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

39.10(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

39.10(7) Inflation protection as provided in this subrule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subrule. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.
[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.11(514D,514G) Requirements for application forms and replacement coverage.

39.11(1) Application forms shall include the following questions designed to elicit information whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by Iowa Code section 514G.103(9)“a,” the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(1) If so, with which company?

(2) If that policy lapsed, when did it lapse?

c. Are you covered by Medicaid?

d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

39.11(2) Producers shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

39.11(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides ten days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER

[BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Producer, Broker or Other Representative)

[Typed Name and Address of Producer or Broker]

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

39.11(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term

care insurance policy delivered herewith issued by [company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

39.11(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

39.11(6) Life insurance policies that accelerate benefits for long-term care shall comply with this subrule if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 191—Chapter 16. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.
[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.12(514G) Reserve standards.

39.12(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Iowa Code section 508.36(3)“a”(7). Claim reserves must also be established when such policy or rider is in claim status.

Reserves for policies and riders subject to this subrule should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event

shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to the subrule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- a. Definition of insured events;
- b. Covered long-term care facilities;
- c. Existence of home convalescence care coverage;
- d. Definition of facilities;
- e. Existence or absence of barriers to eligibility;
- f. Premium waiver provision;
- g. Renewability;
- h. Ability to raise premiums;
- i. Marketing method;
- j. Underwriting procedures;
- k. Claims adjustment procedures;
- l. Waiting period;
- m. Maximum benefit;
- n. Availability of eligible facilities;
- o. Margins in claim costs;
- p. Optional nature of benefit;
- q. Delay in eligibility for benefit;
- r. Inflation protection provisions; and
- s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

39.12(2) When long-term care benefits are provided other than as in subrule 39.12(1), reserves shall be determined in accordance with sound actuarial standards, applied consistently and accepted by the commissioner of insurance.

191—39.13(514D) Loss ratio.

39.13(1) *Applicability.* This rule shall apply to all long-term care insurance policies or certificates except those covered under rules 191—39.26(514G) and 191—39.28(514G).

39.13(2) *Minimum loss ratio.* Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors including:

- a. Statistical credibility of incurred claims experience and earned premiums.
- b. The period for which rates are computed to provide coverage.
- c. Experienced and projected trends.
- d. Concentration of experience within early policy duration.
- e. Expected claim fluctuation.
- f. Experience refunds, adjustments or dividends.
- g. Renewability features.
- h. All appropriate expense factors.
- i. Interest.
- j. Experimental nature of the coverage.
- k. Policy reserves.
- l. Mix of business by risk classification.
- m. Product features such as long elimination periods, high deductibles and high maximum limits.

39.13(3) Accelerated benefits. Subrule 39.13(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Iowa Code section 508.37;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The policy illustration meets the applicable requirements of 191—Chapter 14 regarding illustrations; and

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

191—39.14(514G) Filing requirement. Prior to an insurer or similar organization's offering group long-term care insurance to a resident of this state pursuant to Iowa Code section 514G.103(9) "d," it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.15(514D,514G) Standards for marketing.

39.15(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies by its producers or by other producers will be fair and accurate.

b. Establish marketing procedures to ensure that excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subrule.

f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program.

g. For long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to paragraph 39.6(1) “b.”

h. Provide an explanation of contingent benefit upon lapse provided for in 39.29(6) “c.”

39.15(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

a. *Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. *High-pressure tactics.* Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. *Cold-lead advertising.* Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

d. *Misrepresentation.* Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

39.15(3) Association marketing.

a. When a group long-term care insurance policy is issued to an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations, the association or associations, or the insurer of the association or associations, shall, prior to advertising, marketing or offering the policy within this state, file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

b. When a professional, trade, or occupational association is issued a group long-term care policy for its members or retired members or combination thereof, the association shall have as its primary responsibility, when endorsing or selling long-term care insurance, to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(1) The insurer shall file with the insurance division the following material:

1. The policy and certificate;

2. A corresponding outline of coverage; and

3. All advertisements requested by the insurance division.

(2) The association shall disclose in any long-term care insurance solicitation the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and a brief description of the process under which the policies and the insurer issuing the policies were selected.

(3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(4) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(5) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

2. Actively monitor the marketing efforts of the insurer and its producers; and

3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Numbered paragraphs "1" through "3" shall not apply to qualified long-term care insurance contracts.

(6) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the insurance division the information required in this subrule.

(7) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subrule.

(8) Failure to comply with the filing and certification requirements of this subrule constitutes an unfair trade practice in violation of Iowa Code chapter 507B.

39.15(4) *Producer training requirements.*

a. Purpose. The purpose of this subrule is to require certain specific minimum training for insurance producers who wish to sell long-term care insurance or long-term care partnership insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance and long-term care partnership insurance products. This additional training is also necessary to ensure that insurance producers are able to determine whether long-term care insurance or long-term care partnership insurance products are suitable for consumers and that producers are able to adequately explain to consumers how the long-term care insurance and long-term care partnership insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance and long-term care partnership insurance products understand basic features of the products.

(1) This subrule applies to all long-term care insurance and long-term care partnership insurance products sold on or after January 1, 2010.

(2) For purposes of this subrule, "CE," "CE provider," "CE term" and "credit" shall mean the same as defined in rule 191—11.2(505,522B).

b. Required training.

(1) An individual may not sell, solicit or negotiate long-term care insurance or long-term care partnership insurance products unless the individual is licensed as an insurance producer with an accident and health or sickness line of authority and has completed a one-time training course and ongoing training every CE term thereafter. The training shall meet the requirements set forth in paragraph 39.15(4) "c."

(2) The training content of paragraph 39.15(4) "c" must be approved as continuing education courses under 191—Chapter 11, except that the one-time training required under subparagraph 39.15(4) "b"(1) must be classroom training. However, a CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

c. Training content.

(1) The one-time training required by this subrule shall be no less than eight credits and the ongoing training required by this subrule shall be no less than four credits, except that producers who have completed four credits of long-term care insurance training prior to January 1, 2010, shall complete only four credits of one-time training specifically related to the long-term care partnership program and Iowa-specific Medicaid requirements.

(2) The training required under subparagraph (1) shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership programs, including, but not limited to:

1. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid requirements;

2. Available long-term care services and providers;

3. Changes or improvements in long-term care services or providers;

4. Alternatives to the purchase of private long-term care insurance or long-term care partnership insurance;

5. The effect of inflation on benefits and the importance of inflation protection;

6. Consumer suitability standards and guidelines;

7. The Deficit Reduction Act;

8. Iowa's laws regarding the long-term care partnership program;

9. The Iowa Medicaid program;

10. Miller trusts;

11. Spousal protection;

12. Transfer of assets;

13. Estate recovery; and

14. Eligibility.

(3) Unless otherwise required by state or federal law, the training required by this subrule shall not include training that is specific to a single insurer or company product and shall not include any sales or marketing information, materials, or training, other than those required by state or federal law.

d. Requirements for insurers.

(1) Insurers subject to this chapter shall obtain verification that a producer has received training required by subparagraph 39.15(4) "b"(1) before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance or long-term care partnership insurance products; shall make verifications available to the division upon request; and shall maintain records subject to the state's record retention requirements.

(2) Each insurer subject to this chapter shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the division to provide assurance to the Iowa department of human services that producers have received the training set forth in subparagraph 39.15(4) "c"(2), numbered paragraph "1," as required by subparagraph 39.15(4) "b"(1) and that producers have demonstrated an understanding of the partnership policies and the policies' relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the division upon request.

e. Training obtained in other states. The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state.

f. Requirements for continuing education providers to provide long-term care partnership insurance training. In addition to having been approved as a CE provider under rule 191—11.9(505,522B), a CE provider intending to provide either the initial training or the ongoing continuing education required under subrule 39.15(4) shall:

(1) Provide only classroom training for the initial one-time training for providers. However, the CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

(2) If approved, comply with rules 191—11.10(505,522B) and 191—11.11(505,522B).

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.
[ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—39.16(514D,514G) Suitability.

39.16(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

39.16(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the “issuer”) shall:

- a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
- b. Train its producers in the use of its suitability standards; and
- c. Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

39.16(3) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take into consideration the following:

- a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- b. The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
- c. The values, benefits and costs of the applicant’s existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

39.16(4) The issuer, and, when a producer is involved, the producer, shall make reasonable efforts to obtain the information set out in subrule 39.16(3). The efforts shall include presentation of the “Long-Term Care Insurance Personal Worksheet” to the applicant, at the time of or prior to application. The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer’s personal worksheet shall be filed with the commissioner.

A completed personal worksheet shall be returned to the issuer prior to the issuer’s consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.

39.16(5) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

39.16(6) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

39.16(7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” shall be provided. The form shall be in the format contained in Appendix C, in not less than 12-point type.

39.16(8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternative method of verification shall be made part of the applicant’s file.

39.16(9) The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

[ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—39.17(514G) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

191—39.18(514G) Standard format outline of coverage. This rule, which is not applicable to life policies with long-term care riders attached, implements, interprets and makes specific the provisions of Iowa Code section 514G.105 in prescribing a standard format and the content of an outline of coverage.

39.18(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

39.18(2) In the case of producer solicitations, a producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

39.18(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

39.18(4) The commissioner shall prescribe the standard format, including style, arrangement, and overall appearance and content of an outline of coverage.

39.18(5) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

39.18(6) The outline of coverage shall contain no material of an advertising nature.

39.18(7) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

39.18(8) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

39.18(9) Format for outline of coverage:

[COMPANY NAME]
[ADDRESS — CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or substantially similar language, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [[a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]].

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES.**

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:

(1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Noneligible facilities and provider;
- (c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions and exceptions;
- (e) Limitations.]

[This section should provide a brief, specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in "6" above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE INFORMATION PROGRAM (800-351-4664) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.19(514G) Requirement to deliver shopper's guide.

39.19(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, the Health Insurance Association of America or the senior health insurance information program of the insurance division shall be provided to all prospective applicants of a long-term care insurance policy or certificate or life insurance policy or certificate that includes a long-term care rider.

a. In the case of producer solicitations, a producer must deliver the shopper's guide to the applicant at the time of application.

b. In the case of direct response solicitations, the shopper's guide must be presented to the applicant at the time the policy is delivered.

39.19(2) Insurers offering life insurance policies or riders containing accelerated long-term care benefits are not required to comply with 39.19(1), but shall furnish the policy summary required under rule 191—39.20(514G).

[ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—39.20(514G) Policy summary and delivery of life insurance policies with long-term care riders.

39.20(1) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

39.20(2) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions, and limitations on benefits of long-term care;

d. If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

e. A statement that any long-term care inflation protection option required by rule 191—39.10(514D,514G) is not available under this policy.

The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with 191—Chapter 14 or into the life insurance policy summary which is required to be delivered in accordance with rule 191—15.4(507B).

191—39.21(514G) Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit. Any time a long-term care benefit, funded through life insurance which by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

191—39.22(514G) Unintentional lapse.

39.22(1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing

not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation no less often than once every two years.

39.22(2) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subrule 39.22(1) need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

39.22(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subrule 39.22(1) at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

39.22(4) Reinstatement. In addition to the requirement in subrule 39.22(1), a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

191—39.23(514G) Denial of claims. If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof, provide a written explanation of the reasons for the denial; and make available all information directly related to the denial.

191—39.24(514G) Incontestability period.

39.24(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

39.24(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

39.24(3) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

39.24(4) No long-term care insurance policy or certificate may be field-issued based on medical or health status. For purposes of this subrule, "field-issued" means a policy or certificate issued by a

producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer.

39.24(5) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

39.24(6) In the event of the death of the insured, this rule shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by Iowa Code section 508.28. In all other situations, this rule shall apply to life insurance policies that accelerate benefits for long-term care. [ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—39.25(514G) Required disclosure of rating practices to consumers.

39.25(1) *Applicability.* This rule applies to any new long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force prior to February 1, 2003, the provisions of this rule shall apply on the policy anniversary following February 1, 2003.

39.25(2) *Contents of disclosure.* Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subrule to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subrule to the applicant no later than at the time of delivery of the policy or certificate.

- a. A statement that the policy may be subject to rate increases in the future;
- b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;
- c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
- d. A general explanation for applying premium rate or rate schedule adjustments that shall include:
 - (1) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
 - (2) The right to a revised premium rate or rate schedule as provided in paragraph 39.25(2) "c" if the premium rate or rate schedule is changed;
- e. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state.
 - (1) The following, at a minimum, shall be included:
 1. The policy forms for which premium rates have been increased;
 2. The calendar years when the form was available for purchase; and
 3. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
 - (2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
 - (3) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
 - (4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or on a block of policy forms acquired from nonaffiliated insurers on or before the later of February 1, 2003, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the non-affiliated selling company shall include the disclosure of that rate increase in accordance with paragraph "e."

(5) If the acquiring insurer in subparagraph (4) above files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of

policy forms acquired from nonaffiliated insurers referenced in subparagraph (4), the acquiring insurer shall make all disclosures required by paragraph “e,” including disclosure of the earlier rate increase referenced in subparagraph (4).

39.25(3) Acknowledgment. An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under 39.25(2)“a” and 39.25(2)“e.” If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

39.25(4) Required format. An insurer shall use the forms in Appendices B and F to comply with the requirements of this rule.

39.25(5) Notice of rate increase. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subrule 39.25(2) when the rate increase is implemented.

191—39.26(514G) Initial filing requirements.

39.26(1) Effective date. This rule applies to any long-term care policy issued in this state on or after February 1, 2003.

39.26(2) Required filing. An insurer shall provide the information listed in this subrule to the commissioner pursuant to rule 191—20.1(505,509,514A,515,515A,515F) 30 days prior to making a long-term care insurance form available for sale.

a. A copy of the disclosure documents required in rule 191—39.25(514G); and

b. An actuarial certification consisting of at least the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

1. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

2. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

3. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

4. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

- An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

- If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subrule 39.26(3) based on a standard age distribution; and

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

39.26(3) Demonstration on request.

a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

b. In the event the commissioner asks for additional information under this provision, the period in subrule 39.26(2) does not include the period during which the insurer is preparing the requested information.

191—39.27(514G) Reporting requirements.

39.27(1) Every insurer shall maintain for each producer records of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

39.27(2) Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements as measured by subrule 39.27(1) in the format prescribed in Appendix G.

39.27(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

39.27(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year in the format prescribed in Appendix G.

39.27(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year in the format prescribed in Appendix G.

39.27(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied in the format prescribed in Appendix E.

39.27(7) For purposes of rule 191—39.27(514G):

a. "Policy" means only long-term care insurance;

b. Subject to paragraph "c" below, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

c. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

d. "Report" means on a statewide basis.

39.27(8) Reports required under this rule shall be filed with the commissioner. The first reports under this rule are due June 30, 2004.

[ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—39.28(514G) Premium rate schedule increases.

39.28(1) This rule applies to any long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall apply on the policy anniversary following July 1, 2003.

39.28(2) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders and shall include:

a. Information required by rule 191—39.25(514G);

b. Certification by a qualified actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

- (2) The premium rate filing is in compliance with the provisions of this rule;
 - c. An actuarial memorandum justifying the rate schedule change request that includes:
 - (1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 1. Annual values for the five years preceding and the three years following the valuation date shall be provided separately;
 2. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 3. The projections shall demonstrate compliance with subrule 39.28(3); and
 4. For exceptional increases,
 - The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - In the event the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;
 - (2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
 - (3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
 - (4) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and
 - (5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;
 - d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
 - e. Sufficient information for review of the premium rate schedule increase by the commissioner.
- 39.28(3)** All premium rate schedule increases shall be determined in accordance with the following requirements:
- a. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
 - b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (1) The accumulated value of the initial earned premium multiplied by 58 percent;
 - (2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (3) The present value of future projected initial earned premiums multiplied by 58 percent; and
 - (4) Eighty-five percent of the present value of future projected premiums not in subparagraph (3) above on an earned basis;
 - c. In the event that a policy form has both exceptional and other increases, the values in subparagraphs 39.28(3)“b”(2) and (4) will also include 70 percent for exceptional rate increase amounts; and
 - d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as recommended by the NAIC Financial Examiners Handbook. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

39.28(4) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in subparagraph 39.28(2) “c”(1), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this subrule shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(5) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subparagraph 39.28(2) “c”(1), shall be filed for review by the commissioner every five years following the end of the required period in subrule 39.28(4). For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(6) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subrule 39.28(3), the commissioner may require the insurer to implement any of the following:

- a. Premium rate schedule adjustments; or
- b. Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to subparagraph 39.28(2) “c”(5), if applicable.

39.28(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subrule 39.28(8); and

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subrule 39.28(3) had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs 39.28(3) “b”(1) and (3).

39.28(8) Review of lapse rates.

a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- (1) The rate increase is not the first rate increase requested for the specific policy form or forms;
- (2) The rate increase is not an exceptional increase; and
- (3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

b. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

1. Be subject to the approval of the commissioner;
2. Be based on actuarially sound principles, but not be based on attained age; and
3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(1) The offer shall:

1. Be subject to the approval of the commissioner;
2. Be based on actuarially sound principles, but not be based on attained age; and
3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

39.28(9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subrule 39.28(8), prohibit the insurer from either of the following:

- a. Filing and marketing comparable coverage for a period of up to five years; or
- b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

39.28(10) Subrules 39.28(1) through 39.28(9) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subrule 39.5(16), if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

- (1) Iowa Code section 508.37, regarding nonforfeiture standards for life insurance;
- (2) Iowa Code section 508.38, regarding nonforfeiture standards for individual deferred annuities;

and

- (3) Iowa Code section 508A.5 and 191—subrule 31.3(8), regarding variable annuities;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

- (1) Policy illustrations as required by 191—Chapter 14;
- (2) Disclosure requirements for annuities as required by the commissioner; and
- (3) Disclosure requirements for variable annuities as required by 191—Chapter 31;

e. An actuarial memorandum is filed with the insurance division that includes:

- (1) A description of the basis on which the long-term care rates were determined;
- (2) A description of the basis for the reserves;
- (3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

39.28(11) Subrules 39.28(6) and 39.28(8) shall not apply to group insurance policies where:

a. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

191—39.29(514G) Nonforfeiture.

39.29(1) Except as provided in subrule 39.29(2), a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

39.29(2) When a group long-term care insurance policy is issued, the offer required in subrule 39.29(1) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group as defined in Iowa Code section 514G.103(9) “*d*,” other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

39.29(3) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

39.29(4) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of subrule 39.29(1):

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subrule 39.29(7); and

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

39.29(5) If the offer required to be made under subrule 39.29(1) is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

39.29(6) Benefit triggers.

a. After rejection of the offer required under subrule 39.29(1), for individual and group policies without nonforfeiture benefits issued after February 1, 2003, the insurer shall provide a contingent benefit upon lapse.

b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

c. The contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth below based on the insured’s issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

d. On or before the effective date of a substantial premium increase as defined in paragraph 39.29(6)“*c*,” the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subrule 39.29(7). This option may be elected at any time during the 120-day period referenced in paragraph 39.29(6)“*c*”; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph 39.29(6)“*c*” shall be deemed to be the election of the offer to convert in subparagraph (2) above.

39.29(7) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subrule.

a. For purposes of this subrule, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

b. For purposes of this subrule, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph “*c.*”

c. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subrule 39.29(8).

d. Benefit dates.

(1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding subparagraph (1), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

1. The end of the tenth year following the policy or certificate issue date; or

2. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

39.29(8) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

39.29(9) There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual policies.

39.29(10) The requirements set forth in this rule shall become effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph “*b.*” the provisions of this rule apply to any long-term care policy issued on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall not apply.

39.29(11) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 39.13(2) or 191—39.28(514G), whichever applies, treating the policy as a whole.

39.29(12) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 39.29(6) “*c.*” a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

39.29(13) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

a. The nonforfeiture provision shall be appropriately captioned;

b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium-paying contracts approved by the commissioner for the same contract form; and

c. The nonforfeiture provision shall provide at least one of the following:

- (1) Reduced paid-up insurance;
- (2) Extended term insurance;
- (3) Shortened benefit period; or
- (4) Other similar offerings approved by the commissioner.

39.29(14) Notwithstanding subrule 39.29(10), if an insurer requests a premium rate increase on any long-term care policy issued prior to February 1, 2003, the commissioner shall require as a condition of approval of such premium rate increase that the insurer provide notice to all affected policyholders and certificate holders that, in lieu of the requested premium rate increase, the insured may opt for one of the following:

a. A reduced benefit. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. The reduced benefit offered may include one or more of the following:

- (1) A reduced daily, weekly, or monthly benefit;
- (2) A longer waiting period;
- (3) A reduced benefit period or a reduced maximum lifetime benefit; or
- (4) Any other benefit or coverage reduction option consistent with the policy or certificate design or the carrier's administrative processes.

b. A contingent benefit upon lapse as described in subrules 39.29(7), 39.29(8), 39.29(9), and 39.29(12) if the requested premium rate increase results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in paragraph 39.29(6) "c."

c. Any other alternative mechanism filed by the insurer and approved by the commissioner.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.30(514G) Standards for benefit triggers.

39.30(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

39.30(2) Activities of daily living.

a. Activities of daily living shall include at least the following as defined in rule 191—39.5(514G) and in the policy:

- (1) Bathing;
- (2) Continence;
- (3) Dressing;
- (4) Eating;
- (5) Toileting; and
- (6) Transferring.

b. Insurers may use other activities of daily living to trigger covered benefits as long as the activities are defined in the policy.

39.30(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subrules 39.30(1) and 39.30(2).

39.30(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

39.30(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

39.30(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

39.30(7) The requirements set forth in this rule shall be effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph “*b.*,” the provisions of this rule apply to a long-term care policy issued in this state on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under group long-term care insurance as defined in Iowa Code section 514G.103 that was in force on February 1, 2003, the provisions of this rule shall not apply.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts.

39.31(1) For purposes of this rule, the following definitions apply:

“*Chronically ill individual*” has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

1. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or
2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

“*Licensed health care practitioner*” means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

“*Maintenance or personal care services*” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

“*Qualified long-term care services*” means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(2) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured’s inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

39.31(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subrule 39.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

39.31(5) Certifications required pursuant to subrule 39.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim,

except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

39.31(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

191—39.32(514G) Penalties. Violations of this chapter shall be subject to the penalties imposed under Iowa Code chapter 507B.

191—39.33(514G) Notice of cancellation, nonrenewal or termination of long-term care insurance.

39.33(1) Purpose and definitions.

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer, so as to implement the various policyholder protections intended by Iowa Code section 514G.111 and rule 191—39.22(514G).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

“*Commissioner*” means the Iowa insurance commissioner or insurance division.

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;
2. Notice of an insurance company’s decision or intention not to renew a policy; and
3. For purposes of notices required by Iowa Code section 514G.111 and rule 191—39.22(514G), at a minimum, an insurance company’s notice of lapse or termination of a long-term care insurance policy.

39.33(2) Scope. This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 508 or 515.

39.33(3) Delivery. For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code section 514G.111 and rule 191—39.22(514G) to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code section 514G.111 and rule 191—39.22(514G) for certified mail or certificate of mailing as proof of mailing.

39.33(4) Electronic transmissions. Notwithstanding the requirements of subrule 39.33(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code section 514G.111 and rule 191—39.22(514G).

This rule is intended to implement Iowa Code chapter 505B.

[ARC 1999C, IAB 5/27/15, effective 7/1/15; ARC 2415C, IAB 2/17/16, effective 3/23/16]

191—39.34 to 39.40 Reserved.

DIVISION II
INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

191—39.41(514G) Purpose. This division is intended to implement Iowa Code chapter 514G to provide a uniform process for insureds covered under long-term care insurance to request an independent review of a denial of coverage based on a benefit trigger determination.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.42(514G) Effective date. The rules contained in this division shall apply to all requests for benefit trigger determinations made on or after January 1, 2009.

191—39.43(514G) Definitions. For purposes of this division, the definitions found in Iowa Code section 514G.103 shall apply.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.44(514G) Notice of benefit trigger determination and content. The notice required by Iowa Code section 514G.109 shall contain the following information:

1. The reason that the insurer determined that the policy benefit trigger has not been met by the insured.
2. A description of the internal appeal mechanism provided under the long-term care policy.
3. A description of how the insured, after exhausting the insurer's internal appeal process, has the right to have the benefit trigger determination reviewed under the independent review process required by Iowa Code section 514G.110.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.45(514G) Notice of internal appeal decision and right to independent review. Upon the conclusion of the internal appeal mechanism specified in Iowa Code section 514G.109(2), the notice required in Iowa Code section 514G.110(2) "b" and "c" shall contain the following information:

39.45(1) A description of additional internal appeal rights, if any, offered by the insurer.

39.45(2) A description of how the insured can request independent review of the benefit trigger determination. Such description must specify the following:

- a. The insured must submit a written request within 60 days of the insured's receiving written notice of the insurer's internal appeal decision;
- b. The request must be made to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315;
- c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 3683C, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20]

191—39.46(514G) Independent review request. The insured shall send a copy of the insurer's notice explaining why the benefit trigger has not been met, with the insured's request for an independent review, to the insurance commissioner within 60 days of receipt of the benefit trigger determination. The notice shall be sent to the commissioner at the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

[ARC 3683C, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20; ARC 0001Z, IAB 9/23/20, effective 10/28/20]

191—39.47(514G) Certification process.

39.47(1) The commissioner shall provide written notice of the certification decision to the insurer and the insured within the two-business-day period specified in Iowa Code section 514G.110.

39.47(2) The insurer may appeal the commissioner's certification decision within three business days after receiving notice of the decision. The commissioner shall review any such appeal and promptly notify the insured and the insurer of the commissioner's decision.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.48(514G) Selection of independent review entity.

39.48(1) Within three business days of receiving the commissioner's certification decision, the insurer shall:

- a. Select an independent review entity from the list certified by the commissioner;
- b. Notify the insured in writing of the name, address, and telephone number of the independent review entity;
- c. Notify the independent review entity of its selection and provide the independent review entity with sufficient information to allow selection of qualified licensed health care professionals to conduct the independent review;
- d. Provide the commissioner with copies of the notices required by this subrule.

39.48(2) Within three business days of receiving the notice specified in subrule 39.48(1), the independent review entity shall do one of the following:

a. Accept its selection, designate a qualified licensed health care professional to perform the independent review, and notify the insured and insurer, with a copy to the commissioner, of the designation, the qualifications of the qualified licensed health care professional, and the reasons why the licensed health care professional is qualified to conduct the independent review;

b. Decline its selection and provide notice to the commissioner, the insured, and the insurer of the declination. The insurer shall have three business days after receipt of the declination notice to designate a different independent review entity pursuant to subrule 39.48(1); or

c. Request that the commissioner grant the independent review entity additional time to have a qualified licensed health care professional certified and provide notice of such request to the insured, the insurer, and the commissioner. Within three business days of such a request, the commissioner shall notify the insured, the insurer, and the independent review entity how to proceed.

39.48(3) Within ten days of receiving the notice specified in paragraph 39.48(1) “*b*,” an insured may object to the independent review entity selected by the insurer or the licensed health care professional selected by the independent review entity. Such an objection shall state the reasons for the objection with particularity. The objection shall be sent to the commissioner, and a copy shall be sent to the insurer. The commissioner shall notify the insured, the insurer, and the independent review entity of the commissioner’s decision within two business days of receipt of the objection.

191—39.49(514G) Independent review process.

39.49(1) Within five business days of receiving either the notice provided in paragraph 39.48(1) “*b*,” or the denial of an objection made pursuant to subrule 39.48(3), whichever is later, the insured may submit any additional information or documentation in support of the insured’s claim to both the independent review entity and the insurer.

39.49(2) Within 15 days of receiving the notice provided in paragraph 39.48(1) “*b*,” or within three business days of receiving notice of the denial of an objection made pursuant to subrule 39.48(3), whichever is later, an insurer shall:

a. Provide the independent review entity with any information submitted to the insurer by the insured during the insurer’s internal appeal process relating to the benefit trigger determination that is the subject of the independent review proceeding;

b. Provide the independent review entity with any other relevant documents used by the insurer in making its benefit trigger determination; and

c. Provide the commissioner and the insured with confirmation that the information required by this subrule was submitted to the independent review entity, including the date such information was submitted.

39.49(3) The independent review entity shall not commence its review of the insurer’s benefit trigger determination until 15 business days after either the independent review entity receives the notice of its selection specified in paragraph 39.48(1) “*c*” or the resolution of any objection made pursuant to subrule 39.48(3), whichever is later.

39.49(4) During the time period specified in subrule 39.48(3), the insurer may consider any information provided by the insured pursuant to subrule 39.49(1) and affirm or overturn the insurer’s benefit trigger determination. If the insurer overturns its benefit trigger determination:

a. The insurer shall provide notice to the independent review entity, the commissioner, and the insured of the insurer’s decision; and

b. The independent review process shall immediately cease.

191—39.50(514G) Decision notification.

39.50(1) The independent review entity shall immediately notify the insurer, the insured, and the commissioner of the independent review decision either affirming or overturning the insurer’s benefit trigger determination. The initial notification shall be delivered by telephone or fax transmission, and

a written copy of the decision notification delivered by regular mail. The written copy of the decision shall include a description of the basis for the independent review entity's decision.

39.50(2) If the independent review entity overturns the insurer's decision, the independent review entity shall include all of the following in the decision:

- a. The precise date that the benefit trigger was deemed to have been met;
- b. The specific period of time under review for which the insurer declined eligibility but during which the independent review entity determined that the benefit trigger was met;
- c. For qualified long-term care insurance contracts, a certification made only by a licensed health care practitioner that the insured is a chronically ill individual.

191—39.51(514G) Insurer information.

39.51(1) No later than January 1, 2009, each insurer delivering or issuing for delivery long-term care insurance policies in this state on or after July 1, 2008, and each insurer that has active long-term care policies or riders under which claims for benefits may be made on or after July 1, 2008, shall provide the commissioner the name or title, telephone and fax numbers and email address of an individual who shall be the insurer's contact person for independent review procedures and matters. Any changes in personnel or communication numbers shall be immediately communicated to the commissioner.

39.51(2) Each insurer shall provide the commissioner a detailed description of the process that the insurer has in place to ensure compliance with the requirements of this division and of Iowa Code sections 514G.109 and 514G.110. The description required by this subrule shall be filed in a format as directed by the commissioner on or before March 1, 2009, and thereafter as requested by the commissioner. The description shall include:

- a. An explanation of how the insurer determines when an insured has qualified for independent review of the benefit trigger decision and should receive a notice from the insurer,
- b. A copy of the notice sent to insureds who fall within the scope of the law, and
- c. An explanation of the internal appeal process.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.52(514G) Certification of independent review entity. The following minimum standards are required for certification as an independent review entity:

39.52(1) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding holds a current unrestricted license or certification to practice a health care profession in the United States.

39.52(2) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(3) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is not a physician holds a current certification in the specialty in which that person is licensed by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(4) The entity shall ensure that any licensed health care professionals on its staff who participate in an independent review proceeding have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

39.52(5) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, receive compensation of any type that is dependent on the outcome of the review.

39.52(6) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

39.52(7) The entity shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewers' employment histories and practice affiliations for at least the prior ten years, and a description of past experience with decisions relating to long-term care, functional capacity, and dependency in activities of daily living, or in assessing cognitive impairment.

39.52(8) The entity shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately: licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment; and knowledgeable and experienced in diagnosing a person as a "chronically ill individual" as defined in Section 7702B(c)(2) of the Internal Revenue Code.

39.52(9) The entity shall provide a description of the evaluation tools the entity would use to conduct a review of a long-term care insurance benefit trigger decision.

39.52(10) The entity shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

39.52(11) The entity shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

39.52(12) The entity shall provide a description of the policies and procedures employed to protect confidentiality of individual personally identifiable health information in accordance with applicable state and federal laws.

39.52(13) The entity shall provide a description of the quality assurance program established by the independent review entity.

39.52(14) The entity shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the entity, and the nature and extent of any such ownership or control. The entity must ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

39.52(15) The entity shall provide the names and résumés of all directors, officers and executives of the entity.

39.52(16) The entity shall provide a description of the fees to be charged by the entity for independent reviews of a long-term care insurance benefit trigger decision.

39.52(17) The entity shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

39.52(18) The entity must have on staff or contract with a licensed health care practitioner who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

191—39.53(514G) Additional requirements. The independent review entity shall develop and maintain written policies and procedures governing all aspects of the independent review process. The written policies and procedures include, but are not limited to, the following:

39.53(1) Procedures to ensure that independent reviews are conducted within the time frames specified in this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, and that any required notices are provided in a timely manner.

39.53(2) Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the benefit trigger which is the subject of the benefit trigger decision under review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity) and be deemed experts in the assessment of such benefit trigger.

39.53(3) Procedures to ensure that the insured is notified in writing of the insured's right to object to the independent review entity selected by the insurer or to the licensed health care professional designated

by the independent review entity to conduct the review by filing a notice of objection, along with the reasons for the objection, with the commissioner at the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315, within ten days of the receipt of a notice from the independent review entity.

39.53(4) Procedures to ensure the confidentiality of protected health information records and review materials, in accordance with federal and state law.

39.53(5) Procedures to ensure adherence to the requirements of this division and Iowa Code chapter 514G by any contractor, subcontractor, subvendor, agent or employee affiliated with the independent review entity.

39.53(6) Policies and procedures establishing a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in independent reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.54(514G) Toll-free telephone number. The independent review entity shall establish a toll-free telephone service to receive information relating to independent reviews pursuant to this division and Iowa Code chapter 514G. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to respond to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.55(514G) Division application and reports. The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the independent review process established under Iowa Code chapter 514G. An application for certification as an independent review entity must be submitted in duplicate to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. An application must be submitted in full to be considered. Every applicant will be notified of the certification decision. A list of certified independent review entities shall be maintained at the division and shall be available through the division's website.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

191—39.56 to 39.74 Reserved.

DIVISION III
LONG-TERM CARE PARTNERSHIP PROGRAM

191—39.75(514H) Purpose.

39.75(1) This division is intended to implement Iowa Code chapter 514H and Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171, to establish, in conjunction with the department of human services, a long-term care partnership program in Iowa to provide for financing of long-term care through a combination of private insurance and Iowa Medicaid. This program is also known as the long-term care asset disregard incentive program.

39.75(2) The Iowa long-term care partnership program shall:

a. Provide incentive for individuals to insure against the costs of providing for long-term care needs;

b. Provide a mechanism for individuals to qualify for coverage under Iowa Medicaid while having certain assets disregarded for eligibility determinations and recovery; and

c. Reduce the financial burden on the state's Medicaid program by encouraging the pursuit of private initiatives using qualified long-term care partnership policies or certificates.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.76(514H) Effective date. The rules in this division shall apply to all long-term care partnership policies or certificates sold or issued for delivery on or after January 1, 2010.
[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.77(514H) Definitions. For purposes of this division, the definitions in Iowa Code chapter 514H and rule 191—39.4(514G) shall apply. In addition, the following definitions shall apply:

“*Asset disregard*” means, with regard to the state’s Medicaid program, disregarding assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care partnership policy.

“*Division*” means the Iowa insurance division.

“*Iowa long-term care partnership policy*” or “*partnership policy*” means an insurance policy that meets the following requirements:

1. The policy covers an insured who, when coverage first became effective under the policy, was a resident of Iowa or was an individual eligible under subrule 39.78(2).

2. The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than January 1, 2010.

3. The policy meets all of the applicable requirements of this chapter and Iowa Code chapter 514H.

4. The division has certified the policy as meeting the requirements of the following: Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and any applicable federal regulations or guidelines.

5. The policy provides the following inflation protections:

- For a person who is less than 61 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either annual compounded inflation protection of not less than 3 percent or annual compounded inflation protection of not less than a rate based on changes in the consumer price index. “Consumer price index” means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

- For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either an inflation feature that meets the requirements of this definition, paragraph “5,” first bulleted paragraph, or an automatic inflation feature that provides annual simple inflation increases at a rate of not less than 3 percent.

- For a person who is at least 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, an inflation protection feature may be included in the policy but is not required.

“*Long-term care partnership program*” means a qualified state long-term care insurance partnership as defined in Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

“*Medicaid*” means the program of medical assistance operated by the Iowa department of human services under Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and amendments thereto.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.78(514H) Eligibility.

39.78(1) An individual who is a beneficiary of an Iowa long-term care partnership policy or certificate may be eligible for assistance under the state’s Medicaid program using the asset disregard as provided under Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

39.78(2) An individual who is a beneficiary of a long-term care partnership policy or certificate issued in another state which grants reciprocity to an Iowan who moves to that state is eligible for benefits under Iowa’s Medicaid program using the asset disregard as provided in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723. For purposes of this subrule, “reciprocity” means the granting of all the benefits by one state to an individual who becomes a resident of that state but who purchased a long-term care partnership policy while residing in another state.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.79(514H) Discontinuance of partnership program. If the Iowa long-term care partnership program established by this division and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, is discontinued, any individual who purchased an Iowa long-term care partnership policy or certificate before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.80(514H) Required disclosures.

39.80(1) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a Partnership Program Notice. The notice must be substantially similar to Appendix H of this chapter. The Partnership Program Notice shall be provided with the required outline of coverage.

39.80(2) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a copy of the Iowa Long-Term Care Partnership Program Consumer Guide. The Iowa Long-Term Care Partnership Program Consumer Guide may be found at shiip.iowa.gov.

39.80(3) A partnership policy or certificate issued or issued for delivery in Iowa shall be accompanied by a Partnership Status Disclosure Notice (Appendix I). A similar notice may be used if filed with and approved by the division.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.81(514H) Form filings.

39.81(1) A partnership policy shall not be issued or issued for delivery in Iowa unless filed with and approved by the division. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Issuer Certification. The Partnership Issuer Certification form may be found on the division's website, www.iid.state.ia.us. Insurance companies required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the System for Electronic Rate and Form Filing (SERFF). Insurance companies must comply with the division's requirements, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set forth on the SERFF website at www.serff.org.

39.81(2) Insurers may request to make use of a previously approved policy form as a qualified state long-term care partnership policy. Requests shall be filed electronically via SERFF and according to instructions on the SERFF website.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.82(514H) Exchanges.

39.82(1) An insurer must offer, on a one-time basis, in writing, to all existing policyholders that were issued long-term care policies between February 1, 2003, and January 1, 2010, the option to exchange their existing long-term care policies for an Iowa long-term care partnership policy. The insurer must make this offer within 18 months of the date the insurer begins the first marketing efforts for any long-term care partnership insurance product.

39.82(2) Under an exchange program, an insurer must comply with all of the following:

a. The mandatory offer of an exchange shall apply only to products issued by the insurer that are comparable to the type of policy, such as group policies and individual policies, and to the policy series that the company has certified as partnership-qualified.

b. An insurer must provide the insured a minimum of 90 days from the date of mailing of the offer by the insurer to accept or reject the offer.

c. An insurer must make the offer on a nondiscriminatory basis without regard to the age or health status of the insured. However, the insurer may underwrite if the policy is amended to provide additional benefits or if the exchange would require the issuance of a new policy, except as described in paragraph 39.82(2) "d" below. Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued. Any portion of the policy that

is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

d. If there is no change in coverage that is material to the risk, policies exchanged under this rule shall not be subject to any medical underwriting.

e. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the policy or certificate being replaced.

f. Any portion of the policy that was issued prior to the exchange date shall maintain the policy's original price based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

g. When the policy is issued to a group, the offer required in subrule 39.82(1) shall be made to the group policyholder.

h. Notwithstanding paragraphs 39.82(2) "a" and "c," an insurer is not required to offer an exchange to an individual who is eligible for benefits within an elimination period, who is or who has been in claim status, or who would not be eligible to apply for coverage due to issue age or plan design limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

39.82(3) Policies issued pursuant to this rule shall be considered exchanges and not replacements and are not subject to rule 191—39.11(514D,514G).

39.82(4) A policy received in an exchange after January 1, 2010, is treated as newly issued and is eligible for long-term care partnership policy status. For purposes of applying the Medicaid rules relating to Iowa's long-term care partnership program, the addition of a rider, endorsement or change in schedule page for a policy may be treated as giving rise to an exchange.

39.82(5) An insurer or a producer offering an exchange shall provide to each prospective applicant a Partnership Program Notice, as required by subrule 39.80(1), and a copy of the Iowa Long-Term Care Partnership Program Consumer Guide, as required by subrule 39.80(2). An insurer issuing or issuing for delivery in Iowa an exchange shall provide the policyholder or certificate holder a Partnership Status Disclosure Notice, as required by subrule 39.80(3).

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.83(514H) Required policy terms and disclosures.

39.83(1) A policy or certificate designed or marketed as a long-term care insurance policy or certificate must prominently disclose on the schedule page the following statements:

"Some long-term care insurance [policies or certificates] may qualify under the state's Long-Term Care Partnership Program. Under this Program the [policyholder or certificate holder] may be able to protect some of the [policyholder's or certificate holder's] assets from Medicaid spend-down requirements through a feature known as 'Asset Disregard.' Nothing in this [policy or certificate] is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility. If you have questions about whether or not your policy currently qualifies under the Long-Term Care Partnership Program, please contact [the insurer at ###-###-####] and request a long-term care partnership program policy summary."

39.83(2) If a policyholder or certificate holder or that person's representative requests a long-term care partnership program policy summary, as provided in subrule 39.83(1), the information the insurer shall provide and the format of the long-term care partnership program policy summary shall be as set forth in Appendix J. An insurer may submit a form substantially similar to Appendix J to the commissioner for approval to use as a substitute for Appendix J.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.84(514H) Standards for marketing and suitability. The standards for marketing found in rule 191—39.15(514D,514G) and the suitability requirements of rule 191—39.16(514D,514G) shall apply to the marketing and sale of long-term care partnership policies.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—39.85(514H) Required reports.

39.85(1) Each issuer of partnership-qualified long-term care insurance in this state shall provide regular reports to the Secretary of the United States Department of Health and Human Services in accordance with federal law and regulations and to the Iowa department of human services and the division as provided in Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171. The report shall include information as required by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Submission of the report to the Iowa department of human services or the division is not required if the issuer files the report through the Centers for Medicare and Medicaid Services filing system.

39.85(2) When a policyholder or certificate holder begins receiving any benefits under a policy, the issuer shall begin providing to the policyholder or certificate holder statements of benefits either monthly or within a reasonable time after benefits have been paid. The statements of benefits shall include, at a minimum, detailed information regarding benefits paid and dates of service.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code section 514D.9 and chapters 514G and 514H.

[Filed 4/28/88, Notice 1/13/88—published 5/18/88, effective 7/1/88]

[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]

[Filed 10/25/91, Notice 9/18/91—published 11/13/91, effective 1/1/92]

[Filed 12/3/93, Notice 8/18/93—published 12/22/93, effective 1/26/94]

[Filed 6/5/02, Notice 5/1/02—published 6/26/02, effective 7/31/02]

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

[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]¹

[Filed emergency 12/12/07—published 1/2/08, effective 12/12/07]

[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 1/1/09][◊]

[Filed emergency 12/24/08—published 1/14/09, effective 1/1/09]

[Filed ARC 8271B (Notice ARC 8132B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]

[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 3683C (Notice ARC 3570C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

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

[Editorial change: IAC Supplement 9/23/20]

[Filed ARC 5598C (Notice ARC 5472C, IAB 2/24/21), IAB 5/5/21, effective 6/9/21]

[◊] Two or more ARCs

¹ Effective date of subrule 39.15(4) delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 2007.

APPENDIX A

**RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF IOWA
FOR THE REPORTING YEAR 20[]**

Company Name: _____
Address: _____
Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

APPENDIX B**Long-Term Care Insurance
Personal Worksheet**

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year] [a one-time single premium of \$_____].

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

From my Income From my Savings/Investments My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) Under \$10,000 \$[10-20,000] \$[20-30,000]
 \$[30-50,000] Over \$50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
 No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From my Income From my Savings/Investments My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

APPENDIX C

Things You Should Know Before You Buy**Long-Term Care Insurance**

- Long-Term Care Insurance**
- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
 - [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare**
- Medicare does **not** pay for most long-term care.
- Medicaid**
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
 - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
 - When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
 - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
- Make sure the insurance company or producer gives you a copy of a booklet called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D**Long-Term Care Insurance Suitability Letter**

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

No. I have decided not to buy a policy at this time.

APPLICANT’S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].

APPENDIX E**Claims Denial Reporting Form
Long-Term Care Insurance****For the State of Iowa****For the Reporting Year of _____**

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual GroupInstructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. “Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy ²		
9	• Provider/Facility Not Qualified under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

¹The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

² Example—home health care claim filed under a nursing home only policy.

³ Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

⁴ Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F**Instructions:**

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

**Long-Term Care Insurance
Potential Rate Increase Disclosure Form**

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][\$._____].

Drafting Note: Use “approved” in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premiums.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

Turn the Page

Contingent Nonforfeiture	
Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

APPENDIX G

**Long-Term Care Insurance
Replacement and Lapse Reporting Form**

For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
 Company Address: _____ Company NAIC Number: _____
 Contact Person: _____ Phone Number: (____) _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements As % of Number Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses As % of Number Sold By This Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales _____%
 Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) _____%
 Percentage of Lapsed Policies to Total Annual Sales _____%
 Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX H

Partnership Program Notice
Important Consumer Information Regarding the
Iowa Long-Term Care Partnership Program

Some long-term care insurance policies or certificates sold in Iowa may qualify for the Iowa Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain state and federal requirements. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may protect the policyholder's or certificate holder's assets through a feature known as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid.

All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds \$500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. Therefore, you should consider if Asset Disregard is important to you and whether a partnership policy or certificate meets your needs. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

What Are the Requirements for a Partnership Policy or Certificate?

In order for a policy or certificate to qualify as a partnership policy or certificate, it must, among other requirements:

- Be issued to an individual on or after January 1, 2010;
- Be issued to an individual who is an Iowa resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 7702B(b) of the Internal Revenue Code of 1986;
- Meet the following inflation protection requirements:
 - For a person less than 61 years of age – provides compound annual inflation protection
 - For a person at least 61 but less than 76 years of age – provides 3 percent inflation protection
 - For a person at least 76 years of age – inflation protection may be offered but is not required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy or certificate qualifies as a partnership policy or certificate.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or insurance company to determine the effect of a proposed change. If you move to a state that does not have a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, email address soudeke@dhs.state.ia.us).

APPENDIX I

Partnership Status Disclosure Notice
Important Information Regarding Your Policy's or Certificate's
Long-Term Care Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy.

Some long-term care insurance policies or certificates sold in Iowa qualify for the Iowa Long-Term Care Partnership Program. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may be entitled to special treatment, in particular as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds \$500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

Partnership Policy or Certificate Status

Your long-term care insurance policy or certificate is intended to qualify as a partnership policy or certificate under the Iowa Long-Term Care Partnership Program as of your policy's or certificate's effective date.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or your insurance company to determine the effect of a proposed change. If you move to a state that does not maintain a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change on law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Allison Scott, Medicaid Program Manager, telephone number (515)418-3497, email address ascott@dhs.state.ia.us).

APPENDIX JLong-Time Care Partnership Program Policy Summary

1. Name of insured _____
2. Policy/certificate number _____
3. Effective date of coverage _____
4. The policy/certificate was issued in the state of _____
5. Issue age of the insured at the time the coverage was issued _____
6. The policy/certificate was issued With inflation protection coverage
 Without inflation protection coverage
7. The inflation protection coverage is Simple Inflation Compound Inflation None
8. The inflation protection coverage is currently in effect on the coverage Yes No
If no, the date inflation protection coverage ceased _____
9. The policy is intended to meet the standards of a tax-qualified long-term care policy
 Yes No
10. The cumulative dollar amount of insurance benefits paid \$ _____
(NOTE: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only.)
11. The total dollar amount of insurance benefits remaining available under the policy \$ _____
12. This information is correct as of the date this form was completed, which date was _____
13. The name, telephone number and email address of the person completing this form

Name

Telephone Number

E-mail Address

CHAPTER 72
LONG-TERM CARE ASSET PRESERVATION PROGRAM

191—72.1(514H) Purpose. The purpose of this chapter is to set forth the minimum standards for long-term care insurance policies sold prior to December 31, 2009, that participate in the Iowa long-term care asset preservation program; establish documentation and reporting requirements for issuers of policies or certificates to qualify under the Iowa long-term care asset preservation program; provide full disclosures in the sale of long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program; and facilitate public understanding regarding long-term care insurance and long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.2(514H) Applicability and scope. The requirements of this chapter apply to any long-term care insurance policy or certificate that was authorized for sale by the division of insurance as qualifying under the Iowa long-term care asset preservation program under former Iowa Code chapter 249G. No long-term care insurance policy or certificate which has been approved by the division of insurance as a certified long-term care insurance policy or certificate under this chapter may be advertised, solicited, or issued for delivery in this state after December 31, 2009.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.3(514H) Definitions.

“Asset disregard” means a \$1 increase in the amount of assets an individual who purchases a certified long-term care policy may retain, upon qualification for Medicaid, for each \$1 of benefit paid out under the individual’s certified long-term care policy for Medicaid-eligible long-term care services in determining eligibility for the Medicaid program.

“Asset protection” means the right extended by 441—subrule 75.5(5) to beneficiaries of certified long-term care insurance policies and certificates to an asset disregard under the Iowa long-term care asset preservation program.

“Authorized designee” means any person designated in writing to the insurance company by the policyholder or certificate holder of a certified long-term care policy or certificate for purposes of notification under paragraph 72.7(1)“h.”

“Average daily private pay rate” means the average statewide cost of nursing facility services to a private pay resident as determined by the department of human services in 441—subrule 75.23(3). The average statewide private pay rate is set annually on July 1 for one year by the Iowa department of human services.

“Case management” includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

“Case management agency” means an agency or other entity approved by the Iowa department of human services as meeting Medicaid case management standards.

“Certificate” means any certificate delivered or issued for delivery in this state under a group long-term care policy.

“Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

“Certificate holder” means an owner of a certified long-term care insurance certificate or the beneficiary of a certified long-term care certificate.

“Certified long-term care insurance policy or certificate” means any long-term care insurance policy or certificate certified for sale to Iowa residents by the division of insurance as meeting standards promulgated under rules 191—72.6(514H) and 191—72.7(514H).

“Cognitive impairment” means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer’s disease or similar forms of senility or irreversible dementia. This deterioration or loss of

intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

1. Short-term or long-term memory.
2. Orientation as to person, place, and time.
3. Deductive or abstract reasoning.

Cognitive impairment must result in an individual's requiring 24-hour-a-day supervision or direct assistance to maintain the individual's safety.

"Complex, yet stable medical condition" means that the individual requires 24-hour-a-day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

"Deficiency in activity of daily living" means that the individual cannot perform one or more of the following six activities of daily living without direct assistance:

1. Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.
2. Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
3. Toileting, meaning getting on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.
4. Transferring, meaning moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.
5. Continence, meaning the ability to control bowel and bladder as well as use ostomy or catheter receptacles and apply diapers and disposable barrier pads.
6. Eating, meaning reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

"Department of human services" means the Iowa division of medical services.

"Direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others.

"Formal long-term care services" means long-term care service for which the provider is paid.

"Home health care services" means:

1. Part-time or intermittent skilled nursing services by licensed nursing personnel provided by a home health agency or by a registered nurse or a licensed vocational nurse, when a case management provider agency has determined that no home health agency exists in the area;
2. Home health aide services provided by a home health agency;
3. Physical therapy, occupational therapy, or speech therapy and audiology services provided by a home health agency; and
4. Medical social services by a social worker or social work assistant provided by a home health agency.

"Homemaker services incidental to personal care" means the policyholder or certificate holder is eligible to receive homemaker services if personal care is being received. Homemaker services incidental to personal care are limited to the following:

1. Domestic or cleaning services;
2. Laundry services;
3. Reasonable food shopping and errands;
4. Meal preparation and cleanup;
5. Transportation assistance to and from medical appointments; and

6. Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

A certified long-term care insurance policy or certificate shall not, if it provides homemaker services incidental to personal care, limit or exclude benefits by requiring that the provision of such services be at a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers.

“Informal long-term care services” means long-term care services for which the provider is not paid.

“Insured event” means the insured is eligible to receive insurance benefits and to have these benefits qualify for an asset disregard if any one of the following criteria is met:

1. The insured has at least two deficiencies in activities of daily living (ADLs) (to qualify for home-and community-based services including, but not limited to, home health care, adult day health/social care, personal care, homemaker services incidental to personal care, respite care and residential care facility) or three deficiencies in activities of daily living (ADLs) (to qualify for nursing facility care); or

2. The insured has a cognitive impairment; or

3. The insured has a complex, yet stable medical condition.

“Integrated benefits” means the benefits contained in the policy or certificate can be used interchangeably among the various covered home- or community-based or nursing facility benefits, and there is no limit on the use of any specific covered benefit, except for monthly limits that may be set for home-and community-based care benefits and per diem limits that may be set on nursing facility services.

“Issuer” means:

1. Insurance companies;

2. Fraternal benefit societies;

3. Prepaid health care delivery plans;

4. Health care service plans;

5. Health maintenance organizations; and

6. Any other entity delivering or issuing for delivery in this state, long-term care policies or certificates.

“Long-term care asset preservation program” means the program authorized in former Iowa Code chapter 249G.

“Medicaid-eligible long-term care services” include:

1. Long-term care services available under Iowa’s state Medicaid plan, including care in a licensed nursing facility and home health nursing and home health aide services provided by a home health agency.

2. Long-term care services covered under the Medicaid home- and community-based services waiver for the aged and disabled, as defined in paragraph 72.7(1)“d.”

“Medicaid waiver” refers to the home- and community-based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Iowa to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Iowa’s Medicaid waiver services include:

1. Case management;

2. Homemaker;

3. Respite care;

4. Attendant care;

5. Adult day care; and

6. Other services which, independent of the preceding home- and community-based services, are essential to prevent institutionalization.

“Personal care services” means:

1. Ambulation assistance, including help in walking or moving around (e.g., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of

engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.

2. Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

3. Dressing includes putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

4. Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy or catheter receptacles and urinals, application of diapers and disposable barrier pads.

5. Reposition, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

6. Feeding and hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate; cleaning face and hands as necessary following meal.

7. Assistance with self-administration of medications.

8. A certified long-term care insurance policy or certificate shall not, if it provides personal care services, limit or exclude benefits by requiring that the provision of personal care be at a level of certification or licensure greater than that required by the eligible service, or by limiting benefits to services provided by Medicare-certified agencies or providers.

“Plan of care” means a written individualized plan of services approved by a case management provider agency which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual and the cost, if any, of any formal long-term care services prescribed. Changes in the plan of care must be documented to show that such alterations are required by changes in the client’s medical situation, functional or cognitive abilities, behavioral abilities or the availability of social supports.

“Preadmission review” means the program which requires that each person seeking admission to a nursing facility must be screened and approved for admission in accordance with rule 441—81.3(249A).

“Qualified insured” means the following:

1. An individual who by reason of age is eligible for parts “A” and “B” of the Medicare program (42 U.S.C. 1395 et seq.) who is either:

- The beneficiary of a certified long-term care policy or certificate approved by the division of insurance; or
- Enrolled in a prepaid health care delivery plan that provides long-term care services and qualifies under this rule; or

2. An individual who is eligible for an asset disregard under a certified long-term care policy or certificate. An individual does not have to be a qualified insured to purchase a certified long-term care policy or certificate.

“Quarterly/annually” refers to periods aligning with the state fiscal year of July 1 to June 30.

“Service summary” means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

1. The specific certified policy or certificate.
2. The total benefits paid for services to date.
3. The amount of benefits qualifying for asset protection.

191—72.4(514H) Qualification of long-term care insurance policies and certificates. No long-term care insurance policy or certificate shall qualify for participation in the Iowa long-term care asset preservation program unless the long-term care insurance policy or certificate complies with this chapter. Long-term care insurance policies and certificates in force on July 1, 1994, may, with the signed acceptance of the policyholder or certificate holder, be amended to meet the requirements for qualification.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.5(514H) Standards for marketing. No long-term care insurance policy or certificate which does not meet the requirements of this chapter and has not been approved by the division of insurance as a certified long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a certified long-term care insurance policy or certificate. Each issuer seeking to qualify a long-term care policy or certificate for participation in the Iowa long-term care asset preservation program must do the following:

72.5(1) Provide the consumer, prior to presentation of an application for long-term care insurance, information regarding the availability of consumer information and public education provided by the Senior Health Insurance Information Program using the form developed by the division.

72.5(2) Use applications to be signed by the applicant which indicate, as described as follows, that the applicant:

a. Received a complete description of the Iowa long-term care asset preservation program in a format prescribed by the commissioner, including an explanation of asset protection provided by the program and how it is achieved and the insurance division's Senior Health Insurance Information Program consumer information telephone number.

b. Received a description of the issuer's certified long-term care policy or certificate benefit option meeting the requirements of subrule 72.6(2).

c. Received a statement regarding Medicaid eligibility and benefits that shall be in the following format:

NOTICE TO APPLICANT
REGARDING MEDICAID ELIGIBILITY

I understand that eligibility for Medicaid is not automatic; an application is necessary. My insurance company will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any asset exemptions available to any Iowan applying for Medicaid. I understand that should I wish to apply for public assistance it is my responsibility to apply for Medicaid. I further understand that before receiving Medicaid I will first have to use any additional assets I have not protected. I will also need to meet Medicaid's criteria for medical necessity which may be different from the eligibility criteria used by my private insurance. Once I become a Medicaid recipient, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medicaid services at that time may not be the same services I was receiving under my private long-term care insurance.

(Signature of Applicant(s))

d. Agrees to the release of information by the issuer to the state as may be needed to evaluate the Iowa long-term care asset preservation program and document a claim for Medicaid asset protection, in the following format:

CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care policy or certificate by the [insert issuer name] to the Iowa department of human services for the purposes

of documenting a claim for asset protection under the state Medicaid program, evaluating the Iowa long-term care asset preservation program, and meeting Medicaid audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the state of Iowa.

(Signature of Applicant(s))

e. Received a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

In order for this long-term care policy [certificate] to remain certified by the state of Iowa and qualify to provide asset protection for the state Medicaid program, daily coverage benefits must meet or exceed standards established by the state of Iowa. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy [certificate]. [Insert issuer name] will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy that increases benefits over the policy period and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy [certificate] losing its certified status and no longer being allowed to provide asset protection. It is [insert issuer name]'s responsibility to automatically inflate coverage benefit levels in order to maintain certified status; it is your responsibility to make premium payments in order to maintain certified status.

f. Received a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

72.5(3) Report to the commissioner of the division of insurance all sales involving replacement of existing policies and certificates by certified policies or certificates within 30 days of the issue date of the newly issued certified policy or certificate. The report shall include the following:

- a.* The name and address of the insured.
- b.* The name of the company whose policy or certificate is being replaced.
- c.* The name of the producer replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

72.5(4) Provide producer training as follows:

a. Provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless the producer has completed training covering at least the division's eight-credit outline on the Iowa long-term care asset preservation program.

b. Issuers shall provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless, on an annual basis, the producer completes two hours of continuing education training specifically covering the Iowa long-term care asset preservation program and Medicaid.

c. Issuers shall use only curriculum and instructors approved by the division of insurance. Coursework must be completed in a classroom setting and may not be completed on a "take-home" basis.

d. Issuers shall submit training courses used for continuing education for approval to the outside vendor under contract with the division of insurance at least 30 days prior to the beginning of the course. Requests received later may be disapproved.

72.5(5) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: “THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE IOWA LONG-TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM.”

72.5(6) Long-term care insurance policies or certificates sold after July 1, 1994, that are not certified under the Iowa long-term care asset preservation program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: “THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-800-351-4664.”

72.5(7) Provide that no qualified long-term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner.

72.5(8) Except as provided in this subrule, an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months. The following describe the process and result of discontinuing the availability of a policy form or certificate form:

An issuer may discontinue the availability of a policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. The following shall be considered a discontinuance of the availability of a policy form or certificate form:

- a. The sale or other transfer of a qualified policy form or certificate form to another issuer.
- b. A change in the rating structure or methodology unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(3) An issuer that discontinues the availability of a policy form or certificate form under this subrule shall not file for approval of a new long-term care policy form or certificate form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if: an issuer discontinues a policy form or certificate form as the result of changes to this rule; or all existing policyholders and certificate holders of a discontinued policy form or certificate form are given the opportunity to purchase the new policy form or certificate form without regard to health status, claims experience, or age. Issuers are not required to make this offer to policyholders or certificate holders receiving benefits under the discontinued policy form or certificate form.

[Editorial change: IAC Supplement 9/23/20; ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.6(514H) Minimum benefit standards for qualifying policies and certificates. No long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long-term care insurance policy or certificate which does not meet the minimum benefit

standards in this rule, and which has not been approved by the division of insurance as a qualified long-term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements for long-term care insurance policies or certificates. In order to qualify for participation in the Iowa long-term care asset preservation program, a long-term care insurance policy or certificate shall meet the following:

72.6(1) Contain a “benefit amount maximum” equivalent to at least 365 times the minimum daily nursing facility benefit defined in 72.6(6) “a.”

72.6(2) Offer a maximum benefit amount option equivalent to 365 times the minimum daily nursing facility benefit defined in 72.6(6) “a.” Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

72.6(3) Provide that maximum benefits be available in dollars and not in days of care.

72.6(4) Include a provision of inflation protection which satisfies at least one of the following criteria:

a. The policy or certificate covers at least 80 percent but not more than 110 percent of the average daily private pay rate.

b. The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the consumer price index or at 5 percent each year over the previous year for each year that the contract is in force.

c. The policy or certificate provides the following:

(1) Annual per diem upgrades on a guaranteed issue basis at premiums based on the age of the policyholder or certificate holder at the time of the issuance of the qualified policy or certificate.

(2) Unless the insured takes positive action to decline them, these upgrades automatically increase the level of daily coverage to meet or exceed the minimum inflation adjusted daily benefit. The minimum inflation adjusted daily benefit is defined as the amount or amounts derived by taking the minimum daily benefit for nursing facility care at the time of purchase as specified in 72.6(6) “a” and inflating it by the consumer price index or by at least 5 percent each year over the previous year for each year that the contract is in force. The schedule of minimum per diem dollar amount increases shall be updated and maintained at the division of insurance.

(3) The issuer shall notify those policyholders or certificate holders choosing the upgrade option when the upgrades are automatically effective and what the increased premium, if any, will be. The issuer shall also provide to the policyholder or certificate holder, at the time of the upgrade, the opportunity to decline the upgrade.

(4) The issuer shall notify the policyholder or certificate holder when the insurance policy or certificate will lose its qualification status if the annual per diem benefit upgrade is declined. A qualified policy or certificate containing this inflation protection provision will remain qualified as long as the insured’s daily benefit amount equals or exceeds the minimum inflation adjusted daily benefit.

72.6(5) Provide that the unused maximum benefit amount of the policy or certificate increase proportionately with the inflation protection requirements of 72.6(4).

72.6(6) At a minimum, upon the initial effective date, provide the following:

a. A daily nursing facility benefit of at least 80 percent of the average daily private pay rate in nursing facilities rounded to the next highest \$5 increment. No policy or certificate need pay benefits in excess of the actual charges.

b. A daily home- and community-based benefit of at least 50 percent of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate need pay benefits in excess of the actual charges.

c. The daily home- and community-based benefit shall not exceed the daily nursing facility benefit.

72.6(7) If issued on an expense incurred basis, provide benefits which are equal to at least 80 percent of the per diem cost incurred by the insured.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.7(514H) Required policy and certificate provisions.

72.7(1) All qualified policies and certificates shall meet the following requirements:

a. Have premiums:

(1) Based on the issue age of the applicant; or

(2) Level for the life of the policy or certificate with an adjustment only for the increased benefits resulting from the inflation protection requirements of subrule 72.6(4). Nothing in this rule shall preclude an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

b. Not have premiums based on the attained age of the insured.

c. Include a provision that the policy or certificate will utilize the “insured event” criteria, defined in rule 191—72.3(514H), for determining eligibility for benefits and for determining the amount of asset disregard. Approval for admission to a nursing facility under the “preadmission screening program,” as defined in rule 191—72.3(514H), shall be deemed sufficient but not necessary to meet this insured event criteria.

d. Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home- and community-based care. Home- and community-based care shall include, at a minimum, but not be limited to, the following:

(1) Home health nursing.

(2) Home health aide services.

(3) Attendant care.

(4) Respite care.

(5) Adult day care services.

All home- and community-based services shall include case management services delivered by a case management agency. An asset disregard will be provided for all benefits used by qualified insureds to purchase “Medicaid-eligible long-term care services” as defined in rule 191—72.3(514H).

e. Include a provision which allows for a 30-day period within which coverage may be canceled by the applicant by delivering or mailing the evidence of coverage to the issuer or the producer through whom it was effected for a full refund of any premium that was paid. The policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate to the issuer or its producer for cancellation within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Include a provision which, in the event the qualified policy or certificate is about to lapse or the policy or certificate is about to lose qualification status under 72.6(4) “c”(4), offers the policyholder or certificate holder the option to reduce coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in 72.6(1). The issuer need only allow this offer to be exercised one time. Premiums shall be based on the age of the policyholder or certificate holder at the time of the issuance of the original qualified policy or certificate.

g. Include a provision which, in the event a policyholder or certificate holder lapses a qualified policy or certificate and retains a nonforfeiture benefit, the policy or certificate will maintain its qualification status only so long as the minimum inflation adjusted daily benefit, as defined in 72.6(4) “c”(2), is met or exceeded or the policy or certificate pays at least 80 percent of actual or reasonable charges, and the total of the benefit amount paid to date and the benefit amount available is not less than 365 times the minimum inflation adjusted daily benefit. If at any point while in a nonforfeiture benefit the criteria in this paragraph are not met, the policy or certificate will lose its qualification status and the issuer shall notify the policyholder or certificate holder and the department of insurance of the loss of qualification.

h. Include a provision that, upon sale of a qualified long-term care insurance policy or certificate, the issuer shall do the following:

(1) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that

they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no sooner than 30 days after the beginning of the 30-day grace period for premium payments. The issuer shall permit the policyholder or certificate holder to periodically update the authorized designee. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

Protection against unintended lapse.

I understand that I have the right to designate at least one authorized designee other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

(2) Provide at least a five-month guaranteed reinstatement period for a policyholder or certificate holder whose policy or certificate has lapsed due to nonpayment of premium, who has a cognitive impairment, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

i. Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificate holder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare. An asset disregard will only be provided for benefits the issuer can document were used to purchase Medicaid-eligible long-term care services as defined in rule 191—72.3(514H) for a qualified insured.

j. Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long-term care policy shall not be changed or otherwise modified without the signed acceptance of the certificate holder.

72.7(2) Reserved.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.8(514H) Prohibited provisions in certified policies or certificates. The following provisions may not be included in a certified policy or certificate: a restoration of benefits; a second elimination period; any cap on the daily (as opposed to monthly) home- and community-based care benefits.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.9(514H) Reporting requirements. Unless otherwise noted, the requirements of this rule refer to issuer documentation and reporting requirements for qualified policies and certificates. The reports shall be submitted for each person entitled to benefits under a qualified policy or certificate. Each issuer shall do the following:

72.9(1) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa, a report to the department of human services that will include the following information on all individuals who purchased a qualified policy or certificate during the reporting period:

- a.* Name, address, telephone number, date of birth, sex, marital status, and social security number.
- b.* Policy or certificate identification information, including the following:
 - (1) The policy or certificate form number.
 - (2) The policy or certificate number.
 - (3) The policy or certificate category.
 - (4) The effective date of coverage.
- c.* Policy or certificate elimination period in days by type of service.
- d.* The maximum daily benefit for nursing facility care and for home- and community-based care.
- e.* Maximum lifetime benefit amounts.
- f.* Any options and riders in force.
- g.* Purchase type (upgrade, conversion or new issue).
- h.* Method used for calculation of the inflation protection benefit.
- i.* For expense incurred policies or certificates, the percentage of expenses payable.

j. The annual premium for the policy or certificate, the premium mode (monthly, bank draft, quarterly), and the type of premium calculation (level, issue age, other).

72.9(2) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who have changed or amended qualified policies or certificates during the reporting period:

- a.* Name, address, telephone number, and social security number.
- b.* Effective date of the policy or certificate change or coverage amendment.
- c.* A description of the new policy or certificate or amended policy or certificate as described in 72.9(1).

72.9(3) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who dropped their policies or certificates during the reporting period:

- a.* Name, address, telephone number, and social security number.
- b.* The date the policy or certificate was dropped.
- c.* The reason the policy or certificate was dropped, including any of the following:
 - (1) Death of insured.
 - (2) Converted policy or certificate.
 - (3) Maximum benefits expended.
 - (4) Recision.
 - (5) Voluntarily.
 - (6) Qualification of the policy or certificate lost.
 - (7) Other.
 - (8) Unknown.

72.9(4) Maintain a registry and submit on a quarterly basis in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who are denied a qualified policy or certificate during the reporting period:

- a.* Name, address, telephone number, date of birth, sex, marital status and social security number.
- b.* Reason for denial of the application, including the following:
 - (1) Application was not complete.
 - (2) Age was not in allowable range.
 - (3) Eligibility for Medicaid.
 - (4) Medical or other reasons.
 - (5) Other.

72.9(5) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who were assessed for long-term care and benefit eligibility during the reporting period:

- a.* Name, address, telephone number, and social security number.
- b.* Date the assessment was conducted.
- c.* Name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for asset protection.
- d.* A listing of the insured event criteria met for all persons assessed, including complex, unstable medical conditions, deficiencies in activities of daily living, and cognitive impairment.

72.9(6) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on each service used and benefits claimed during the reporting period for each insured:

- a.* Name, address, telephone number, and social security number.
- b.* Whether the policyholder or certificate holder was currently enrolled in Medicare Parts A and B (42 U.S.C. 1395 et seq.) and either:
 - (1) A beneficiary of a Medicare supplement insurance policy or certificate approved by the division of insurance.
 - (2) Enrolled in a prepaid health care delivery plan that provides acute care and preventive service;

or

(3) Covered under a contract under Section 1876 or 1833 of the Social Security Act (42 U.S.C. 1395 et seq.).

- c. Service or procedure code.
- d. Whether the claim for the service was denied or approved.
- e. Start and end date for the service.
- f. Number of units of service and amount billed.
- g. Amount paid by the policy or certificate and the amount paid which counts toward the asset protection.

72.9(7) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on the following aggregate information for the reporting period:

a. The number of applications for qualified long-term care insurance policies and certificates received during the quarter.

b. The number of persons denied a qualified policy or certificate and the reason for denial. Reasons for denial to be specified include the following:

- (1) Application was incomplete.
- (2) Age was not in allowable range.
- (3) Eligibility for Medicaid.
- (4) Medical or health reasons.
- (5) Other.

c. The number of qualified policies and certificates purchased during the quarter.

d. The number of qualified policyholders and certificate holders who dropped their qualified policy or certificate during the quarter for any of the following reasons:

- (1) Death of insured.
- (2) Converted policy or certificate.
- (3) Maximum benefits expended.
- (4) Recision.
- (5) Voluntarily.
- (6) Qualification of the policy or certificate lost.
- (7) Other.
- (8) Unknown.

e. The number of beneficiaries of qualified policies and certificates in force at the end of the quarter.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.10(514H) Maintaining auditing information.

72.10(1) Each issuer shall maintain information as stipulated in 72.10(6) on all policyholders or certificate holders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificate holder's condition which is not otherwise required by federal or state statute or regulation.

72.10(2) When a policyholder or certificate holder who has received any benefit dies or lapses the policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five years after the time when the policy was in force. Unless notified by the division of insurance to the contrary during this period, after the five years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost-effective method of record storage as alternatives to storage of paper copies of stipulated information.

72.10(3) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificate holder of the right to request service records as stipulated in 72.10(6).

72.10(4) The issuer shall also, upon request in writing, provide such policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if any, with a copy of the issuer's service

records as required in 72.10(6) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if requested, within 60 days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

72.10(5) The issuer shall enclose with the records a statement advising the former policyholder or certificate holder that it is in the best interest of the former policyholder or certificate holder to retain the records to establish eligibility for Medicaid.

72.10(6) The information to be maintained includes the following:

a. Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(1) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(2) By an assessment conducted as part of the preadmission screening program of the Iowa Foundation of Medical Care.

(3) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(4) For persons for whom subparagraphs (1) through (3) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (1) through (3). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

b. Description of services provided under the policy or certificate, including the following:

(1) Name, address, telephone number, and license number, if applicable, of provider.

(2) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(3) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(4) The charges of the service providers, including copies of invoices for all services counting toward asset protection.

(5) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(6) Determination of whether the policyholder or certificate holder was a qualified insured at the time of benefit payment. The issuer may rely on written representation by the policyholder or certificate holder as to whether the required coverages were held.

c. In order for home- and community-based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificate holder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(1) A copy of the original plan of care.

(2) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count toward asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count toward asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.11(514H) Reporting on asset protection.

72.11(1) Each issuer shall send an asset protection report at least quarterly to each policyholder or certificate holder who has received any benefits since the last asset protection report sent to the policyholder or certificate holder. Each asset protection report shall include the following information:

- a.* The amount of asset protection for which the policyholder or certificate holder had qualified prior to the quarter covered by the report.
- b.* The total benefits paid by the issuer for services rendered during the quarter.
- c.* A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.
- d.* A summary total of the amount paid to date under the policy or certificate which qualifies for asset protection.

72.11(2) Asset protection reports shall be subject to audit by the division of insurance under the same requirements as specified in 72.13(1) “*b.*”

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.12(514H) Preparing a service summary.

72.12(1) Each issuer shall prepare a service summary at the client’s request specifically for the policyholder or certificate holder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificate holder has exhausted benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificate holder, whichever occurs first.

72.12(2) The service summary shall identify the following:

- a.* The specific qualified policy or certificate.
- b.* The total benefits paid for services rendered to date.
- c.* The amount qualifying for asset protection.

This service summary is separate and in addition to any other information requirement in this chapter.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.13(514H) Plan of action.

72.13(1) Each issuer shall, prior to qualification by the division of insurance, submit to the department of human services a plan for complying with the information maintenance and documentation requirements set forth in rules 191—72.9(514H) and 191—72.10(514H). No policy or certificate shall be qualified until the department of human services has approved the issuer’s documentation plan for the policy or certificate. The documentation plan will include the following:

a. The location where records will be kept. Records required for purposes of the Iowa long-term care asset preservation program must be available at no more than three locations, each of which shall be easily accessible to the division of insurance.

b. The issuer shall agree to give the commissioner access to all information described in rule 191—72.10(514H) on an aggregate basis for all policyholders or certificate holders and on an individual basis for all policyholders or certificate holders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the commissioner to determine if an issuer’s system for documenting asset protection is functioning correctly. The commissioner shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

c. The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the department of human services and the division of insurance concerning the information.

d. Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

- (1) Documentation of the insured event.
- (2) Description of services.
- (3) Documentation of charges and benefits paid.
- (4) Documentation of plans of care, when required.

e. Description of electronic and manual systems which will be used in maintaining the required information.

f. Information that will be retained which is needed to comply with this rule.

g. Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

72.13(2) After the department of human services reviews a plan of action, that department shall advise the division of insurance and the issuer in writing whether the department of human services approves the plan of action. If the department of human services disapproves a plan of action, that department shall advise the division of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.14(514H) Auditing and correcting deficiencies in issuer record keeping.

72.14(1) Within one year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner of insurance or department of human services deems necessary thereafter, the commissioner of insurance or department of human services shall conduct a systems audit of that company's records. The issuer shall be responsible for advising the department of human services and the division of insurance when this one-year period has begun. The commissioner or department of human services shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation.

72.14(2) The department of human services shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. The department of human services shall have the final decision concerning sample sizes and other auditing methods. The department of human services shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. The department of human services shall also notify the issuer of any obligations described in this subrule to hold clients harmless.

72.14(3) The department of human services may enter into voluntary arrangements with issuers of qualified long-term care insurance policies and certificates under which the department of human services would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the department of human services concerning whether services qualify for asset protection shall be binding upon the department of human services in all subsequent actions, and the department of human services shall not make any assertion contradicting these determinations in any action arising in this subrule:

a. All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the department of human services in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

- (1) Whether the insured event has occurred and has been adequately documented.
- (2) Whether a care plan is required.
- (3) Whether a revision of a care plan is required.
- (4) Whether a service or services are in accord with the care plan.
- (5) Whether a service is of such a nature as to qualify for asset protection.
- (6) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

b. The department of human services or one of its other authorized individuals may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

- (1) Assessments.
- (2) Care plans.
- (3) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information is later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the department of human services or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of 72.14(6) and 72.14(7) will apply in the same manner as for any other policyholder or certificate holder.

c. The department of human services or its authorized individual shall render a determination on each request in writing. Each determination of the department of human services or its other authorized individual shall state the reason for the determination, including the following:

- (1) Relevant facts.
- (2) Documentation of facts.
- (3) Statutes.
- (4) Regulations.
- (5) Policies.

d. A copy of all determinations of the department of human services or its authorized individual shall be kept on file at the department of human services, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized producer.

72.14(4) When an audit or other review by the department of human services or the division of insurance reveals deficiencies in the record-keeping procedures of an issuer, the department of human services or the division of insurance will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by the department of human services within a reasonable period of time, the department of human services will notify the division of insurance of the deficiencies. If an issuer fails to correct deficiencies discovered by the division of insurance within a reasonable period of time, the division will notify the department of human services of the deficiencies.

72.14(5) The commissioner of insurance shall reserve the right to remove qualification status of long-term care insurance policies and certificates when deemed necessary. If the division of insurance removes qualification status from a long-term care insurance policy or certificate, a policyholder or certificate holder who purchased a policy or certificate while the policy or certificate was qualified will retain the right to asset protection. A policyholder or certificate holder who purchases a policy or certificate after the removal of qualification status will have no right to asset protection.

72.14(6) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(7) If the department of human services determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that the department of human services cannot determine whether the policyholder or certificate holder qualifies for asset protection, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(8) The commissioner of insurance and the department of human services shall consult on all audits and examinations that may be required to determine compliance with this rule.

72.14(9) Compliance with 72.14(6) and 72.14(7) is a requirement for a policy or certificate to retain qualification.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

191—72.15(514H) Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

[ARC 5598C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapter 514H.

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CHAPTER 20
SERVICE SUPPLIED BY ELECTRIC UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—20.1(476) General information.

20.1(1) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, content and filing of reports, documents and other papers necessary to carry out the provisions of this law.

Iowa Code chapter 478 provides that the Iowa utilities board shall have power to make and enforce rules relating to the location, construction, operation and maintenance of certain electrical transmission lines.

The application of the rules in this chapter to municipally owned utilities furnishing electricity is limited by Iowa Code section 476.1B, and the application of the rules in this chapter to electric utilities with fewer than 10,000 customers and to electric cooperative associations is limited by the provisions of Iowa Code section 476.1A.

20.1(2) *Application of rules.* The rules shall apply to any electric utility operating within the state of Iowa subject to Iowa Code chapter 476, and to the construction, operation and maintenance of electric transmission lines to the extent provided in Iowa Code chapter 478, and shall supersede all tariffs on file with the board which are in conflict with these rules.

These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities.

A request to waive the application of any rule on a permanent or temporary basis may be made in accordance with 199—1.3(17A,474,476).

The adoption of these rules shall in no way preclude the board from altering or amending them pursuant to statute or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

These rules shall in no way relieve any utility from any of its duties under the laws of this state.

20.1(3) *Definitions.* The following words and terms, when used in these rules, shall have the meaning indicated below:

“Acid Rain Program” means the sulfur dioxide and nitrogen oxides air pollution control program established pursuant to Title IV of the Act under 40 CFR Parts 72-78.

“Act” means the Clean Air Act, 42 U.S.C. Section 7401, et seq.

“Affected unit” means a unit or source that is subject to any emission reduction requirement or limitation under the Acid Rain Program, the Clean Air Interstate Rule (CAIR), the Cross-State Air Pollution Rule (CSAPR), or the Mercury and Air Toxics Standards (MATS), or a unit or source that opts in under 40 CFR Part 74.

“Allowance” means an authorization, allocated by the United States Environmental Protection Agency (EPA), to emit sulfur dioxide (SO₂) under the Acid Rain Program or SO₂ and nitrogen oxide (NO_x) under the Clean Air Interstate Rule (CAIR) and the Cross-State Air Pollution Rule (CSAPR) during or after a specified calendar year.

“Allowance futures contract” is an agreement between a futures exchange clearinghouse and a buyer or seller to buy or sell an allowance on a specified future date at a specified price.

“Board” means the utilities board.

“Capacity” means the instantaneous rate at which energy can be delivered, received, or transferred, measured in kilowatts.

“Clean Air Interstate Rule” or *“CAIR”* means the requirements EPA published in the Federal Register (70 Fed. Reg. 25161) on May 12, 2005.

“Complaint,” as used in these rules, is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility obligation.

“*Compliance plan*” means the document submitted for an affected source to the EPA which specifies the methods by which each affected unit at the source will meet the applicable emissions limitation and emissions reduction requirements.

“*Cross-State Air Pollution Rule*” or “*CSAPR*” means the requirements established by EPA in 40 CFR 97 Subparts AAAAA, BBBB, CCCCC, and DDDDD as amended by 81 FR 13275 (March 14, 2016).

“*Customer*” means any person, firm, association, or corporation, any agency of the federal, state or local government, or legal entity responsible by law for payment for the electric service or heat from the electric utility.

“*Delinquent*” or “*delinquency*” means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

“*Distribution line*” means any single or multiphase electric power line operating at nominal voltage in either of the following ranges: 2,000 to 26,000 volts between ungrounded conductors or 1,155 to 15,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

“*Electric plant*” includes all real estate, fixtures and property owned, controlled, operated or managed in connection with or to facilitate production, generation, transmission, or distribution, in providing electric service or heat by an electric utility.

“*Electric service*” is furnishing to the public for compensation any electricity, heat, light, power, or energy.

“*Emission for emission trade*” is an exchange of one type of emission for another type of emission. For example, the exchange of SO₂ emission allowances for NO_x emission allowances.

“*Energy*” means electric energy measured in kilowatt hours.

“*Gains and losses from allowance sales*” are calculated as the difference between the sale price of allowances sold during the month and the weighted average unit cost of inventoried allowances.

“*Mercury and Air Toxics Standards*” or “*MATS*” means the requirements established by EPA in 40 CFR Parts 60 and 63 regarding limits of power plant emissions of toxic air pollutants (February 16, 2012).

“*Meter*” means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

“*Operating reserve*” is a reserve generating capacity required to ensure reliability of generation resources.

“*Peaking power*” is power and associated energy intended to be available at all times during the commitment and anticipated to have low load factor use.

“*Power*” means electric power measured in kilowatts.

“*Price hedging*” means using futures contracts or options to guard against unfavorable price changes.

“*Rate-regulated utility*” means any utility, as defined in 20.1(3), which is subject to board rate regulation under Iowa Code chapter 476.

“*Secondary line*” means any single or multiphase electric power line operating at nominal voltage less than either 2,000 volts between ungrounded conductors or 1,155 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

“*Service limitation*” means the establishment of a limit on the amount of power that may be consumed by a residential customer through the installation of a service limiter on the customer’s meter.

“*Service limiter*” or “*service limitation device*” means a device that limits a residential customer’s power consumption to 3,600 watts (or some higher level of usage approved by the board) and that resets itself automatically, or can be reset manually by the customer, and may also be reset remotely by the utility at all times.

“*Speculation*” means using futures contracts or options to profit from expectations of future price changes.

“*Tariff*” means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the board by an electric utility in fulfilling its role of furnishing service.

“*Timely payment*” is a payment on a customer’s account made on or before the date shown on a current bill for service, or on a form which records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date which determines application of a late payment charge to the current bill or future collection efforts.

“*Transmission line*” means any single or multiphase electric power line operating at nominal voltages at or in excess of either 69,000 volts between ungrounded conductors or 40,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

“*Utility*” means any person, partnership, business association or corporation, domestic or foreign, owning or operating any facilities for providing electric service or heat to the public for compensation.

“*Vintage trade*” is an exchange of one vintage of allowances for another vintage of allowances with the difference in value between vintages being cash or additional allowances.

“*Weighted average unit cost of inventoried allowances*” equals the dollars in inventory at the end of the month divided by the total allowances available for use at the end of the month.

“*Wheeling service*” is the service provided by a utility in consenting to the use of its transmission facilities by another party for the purpose of scheduling delivery of power or energy, or both.

20.1(4) Abbreviations. The following abbreviations may be used where appropriate:

ANSI—American National Standards Institute, 1430 Broadway, New York, New York 10018.

DOE—Department of Energy, Washington, D.C. 20426.

EPA—United States Environmental Protection Agency.

FCC—Federal Communications Commission, 1919 M Street, Washington, D.C. 20554.

FERC—Federal Energy Regulatory Commission, Washington, D.C. 20426.

NARUC—National Association of Regulatory Utility Commissioners, P.O. Box 684, Washington, D.C. 20044.

NBS—National Bureau of Standards, Washington, D.C. 20234.

NFPA—National Fire Protection Association, 470 Atlantic Ave., Boston, Massachusetts 02210.

[ARC 7976B, IAB 7/29/09, effective 9/2/09; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.2(476) Records, reports, and tariffs.

20.2(1) Location and retention of records. Unless otherwise specified by this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of 199—Chapter 18.

20.2(2) Tariffs to be filed with the board. The schedules of rates and rules of rate-regulated electric utilities shall be filed with the board and shall be classified, designated, arranged and submitted so as to conform to the requirements of this chapter. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification and content of tariffs shall be in accordance with these rules. A rate-regulated electric utility’s current tariff will be made available through the board’s electronic filing system.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not be required to file schedules of rates, rules, or contracts primarily concerned with a rate schedule with the board and shall not be subject to the provisions related to rate regulations, but nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board’s duties upon request to do so by the board.

20.2(3) Form and identification. All tariffs shall conform to the following rules:

a. The tariff shall be filed electronically using the board’s electronic filing system. The filed tariff shall be capable of being reproduced on 8½- × 11- inch paper so customers may readily view and reproduce copies of the tariff. A tariff filed with the board may be the same format as is required by a federal agency provided that the rules of the board as to title page; identity of superseding, replacing or revision sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue,

effective date; and the words “Tariff with board” shall apply in the modification of the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show:

- (1) The first page shall be the title page which shall show:
 - (Name of Public Utility)
 - Electric Tariff
 - Filed with
 - Iowa Utilities Board

(Date)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it supersedes a tariff on file and the number being superseded or replaced, for example:

TARIFF NO. _____
 SUPERSEDES TARIFF NO. _____

(3) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly indicate the part eliminated.

(4) Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

- (C)—Changed regulation
- (D)—Discontinued rate or regulation
- (I)—Increase in rate or new treatment resulting in increased rate
- (N)—New rate, treatment or regulation
- (R)—Reduction in rate or new treatment resulting in reduced rate
- (T)—Change in text only

c. All sheets except the title page shall have, in addition to the above-stated requirements, the following information:

(1) Name of utility under which shall be set forth the words “Filed with board.” If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

- (2) Issuing official and issue date.
 - (3) Effective date (to be left blank by rate-regulated utilities).
- d. All sheets except the title page shall have the following form:

(Company Name)	(Part identification)
Electric Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)
	(Content or tariff)
Issued: (Date)	Effective:
Issued by: (Name, title)	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility. The effective date will be left blank by rate-regulated utilities and shall be determined by the board. The utility may propose an effective date.

20.2(4) Content of tariffs.

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear showing the sheet numbers of the first page of each rate schedule or other section. In the event

the utility filing the tariff elects to segregate a section such as general rules from the section containing the rate schedules or other sections, it may at its option prepare a separate table of contents for each such segregated section.

- b.* A preliminary statement containing a brief general explanation of the utility's operations.
- c.* All rates for service with indication for each rate of the type and voltage of service and the class of customers to which each rate applies. There shall also be shown any limitations on loads and type of equipment which may be connected, the net prices per unit of service and the number of units per billing period to which the net prices apply, the period of billing, the minimum bill, any effect of transformer capacity upon minimum bill or upon the number of kWh in any step of the rate, method of measuring demands, method of calculating or estimating loads in cases where transformer capacity has a bearing upon minimum bill or size of rate steps, level payment plan, and any special terms or conditions applicable. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.
- d.* The voltage and type of service, (direct current or single or polyphase alternating current) supplied in each municipality, but without reference required to any particular part thereof.
- e.* Forms of standard contracts required of customers for the various types of service available.
- f.* If service to other utilities or municipalities is furnished at a standard filed rate, either a copy of each signed contract or a copy of the standard uniform contract form together with a summary of the provisions of each signed contract. The summary shall show the principal provisions of the contract and shall include the name and address of the customer, the points where energy is delivered, rate, term, minimum, load conditions, voltage of delivery and any special provisions such as rentals. Standard contracts for such sales as that of energy for resale, street lighting, municipal athletic field lighting, and for water utilities may be filed in summary form as above outlined.
- g.* Copies of special contracts for the purchase, sale, or interchange of electrical energy. All tariffs must provide that, notwithstanding any other provision of this tariff or contract with reference thereto, all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.
- h.* A list of all communities in which service is furnished.
- i.* The list of service areas and the rates shall be filed in a form to facilitate ready determination of the rates available in each municipality and in unincorporated communities that have service. If the utility has various rural rates, the areas where the same are available shall be indicated.
- j.* Definitions of classes of customers.
- k.* Extension rules for extending service to new customers indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included.
- l.* Type of construction which the utility requires the customer to provide if in excess of the Iowa electric safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.
- m.* Specification of such portion of service as the utility furnishes, owns, and maintains, such as service drop, service entrance cable or conductors, conduits, service entrance equipment, meter and socket. Indication of the portions of interior wiring such as range or water heater connection, furnished in whole or in part by the utility, and statement indicating final ownership and responsibility for maintaining equipment furnished by utility.
- n.* Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and terms upon which such construction will be permitted, with due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.
- o.* Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.
- p.* Rules governing the establishment and maintenance of credit by customers for payment of service bills.

- q.* Rules governing the procedure followed in disconnecting and reconnecting service.
- r.* Notice required from a customer for having service discontinued.
- s.* Rules covering temporary, emergency, auxiliary and stand-by service.
- t.* Rules covering the type of equipment which may or may not be connected, including rules such as those requiring demand-limiting devices or power-factor corrective equipment.
- u.* General statement of the method used in making adjustments for wastage of electricity when accidental grounds exist without the knowledge of the customer.
- v.* Statements of utility rules on meter reading, bill issuance, customer payment, notice of delinquency, and service discontinuance for nonpayment of bill.
- w.* Rules for extending service in accordance with 20.3(13).
- x.* If a sliding scale or automatic adjustment is applicable to regulated rates and charges of billed customers, the manner and method of such adjustment calculation shall be covered through a detailed explanation.
- y.* Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.
- z.* Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.

20.2(5) *Annual, periodic and other reports to be filed with the board.*

- a.* System map verification. The utility shall file annually a verification that it has a currently correct set of utility system maps in accordance with the general requirements of subrule 20.3(11) and a statement as to the location of the utility's offices where such maps, except those deemed confidential by the board, are accessible and available for examination by the board or its agents. The verification and map location information shall also be reported to the board upon other occasions when significant changes occur in either the maps or location of the maps.
- b.* Accident reports. Rescinded IAB 12/11/91, effective 1/15/92. See 199—25.5(476,478).
- c.* Rescinded IAB 11/13/02, effective 12/18/02.
- d.* Electric service record. Each utility shall compile a monthly record of electric service showing the production, acquisition and disposition of electric energy, the number of customer terminal voltage investigations made, the number of customer meters tested and such other information as may be required by the board. The monthly "Electric Service" record shall be compiled not later than 30 days after the end of the month covered and such record shall, upon and after compilation, be kept available for inspection by the board or its staff at the utility's principal office within the state of Iowa. A summary of the 12 monthly "Electric Service" records for each calendar year shall be attached to and submitted with the utility's annual report to the board.
- e.* The utility shall keep the board informed currently by written notice as to the location at which the utility keeps the various classes of records required by these rules.
- f.* The utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, electrical contractors, etc., covering meter and service installations shall be maintained and made available to the board upon request.
- g.* A copy of each type of customer bill form in current use shall be filed with the board.
- h.* A copy of the adjustment calculation shall be provided the board prior to each billing cycle on the forms adopted by the board.
- i.* Rescinded IAB 1/9/91, effective 2/13/91.
- j.* Residential customer statistics. Each rate-regulated electric utility shall file with the board on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:
 - (1) Number of accounts;
 - (2) Number of accounts certified as eligible for energy assistance since the preceding October 1;
 - (3) Number of accounts past due;
 - (4) Number of accounts eligible for energy assistance and past due;
 - (5) Total revenue owed on accounts past due;

- (6) Total revenue owed on accounts eligible for energy assistance and past due;
- (7) Number of disconnection notices issued;
- (8) Number of disconnection notices issued on accounts eligible for energy assistance;
- (9) Number of disconnections for nonpayment;
- (10) Number of reconnections;
- (11) Number of accounts determined uncollectible; and
- (12) Number of accounts eligible for energy assistance and determined uncollectible.

k. List of persons authorized to receive board inquiries. Each utility shall file with the board in the annual report required in 199—subrule 23.1(2) a list of names, titles, addresses, and telephone numbers of persons authorized to receive, act upon, and respond to communications from the board in connection with: (1) general management duties; (2) customer relations (complaints); (3) engineering operations; (4) meter tests and repairs; (5) franchises for electric lines; (6) certificates for electric generating plants. Each utility shall file with the board a telephone contact number where the board can obtain current information 24 hours a day about outages and interruptions of service from a knowledgeable person. The contact information required by this paragraph shall be kept current as changes or corrections are made.

This rule is intended to implement Iowa Code section 476.2.
[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.3(476) General service requirements.

20.3(1) *Disposition of electricity.* The meter and associated instrument transformers shall be owned by the utility. The wiring between the instrument transformers and the meter shall be owned or controlled by the utility. The utility shall place a visible seal on all meters in customer use, such that the seal must be broken to gain entry.

- a.* All electricity sold by a utility shall be on the basis of meter measurement except:
 - (1) Where the consumption of electricity may be readily computed without metering; or
 - (2) For temporary service installations not otherwise metered.
- b.* The amount of all electricity delivered to multioccupancy premises within a single building, where units are separately rented or owned, shall be measured on the basis of individual meter measurement for each unit, except in the following instances:
 - (1) Where electricity is used in centralized heating, cooling, water-heating, or ventilation systems;
 - (2) Where a facility is designated for elderly or handicapped persons;
 - (3) Where submetering or resale of service was permitted prior to 1966;
 - (4) Where individual metering is impractical. “Impractical” means:
 - 1. Conditions or structural barriers exist in the multioccupancy building that would make individual meters unsafe or physically impossible to install; or
 - 2. The cost of providing individual metering exceeds the long-term benefits of individual metering; or
 - (5) Where the benefits of individual metering (reduced and controlled energy consumption) are more effectively accomplished through a master meter arrangement.
 - 1. A new multioccupancy building qualifies for master metering under this subparagraph if the predicted annual energy use would result in at least a 30 percent energy savings compared to the predicted annual energy use of a new building meeting the requirements of the State of Iowa Energy Code and operating with equipment, fixtures, and appliances meeting federal energy standards for manufactured devices for a new building.
 - 2. An existing multioccupancy building qualifies for master metering under this subparagraph when the predicted annual energy use would result in at least a 20 percent energy savings compared to the building’s current annual energy usage levels.
 - 3. Credits for on-site renewable energy generation shall not be taken into account when determining the predicted energy savings.
 - 4. A report from a qualified, independent third party stating that the proposed building or renovation will meet the energy savings requirements of this subparagraph shall establish a rebuttable

presumption of eligibility for master metering. “Qualified, independent third party” means a licensed architect or engineer, a certified residential energy services network home energy rating system (RESNET HERS) rater, or any other professional deemed qualified by the board.

If a multioccupancy building is master-metered, the end-user occupants may be charged for electricity as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the electric service is used, the total charge for electric service shall not exceed the total electric bill charged by the utility for the same period.

c. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multioccupancy premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 20.3(1)“*b*” have been met.

d. For purposes of this subrule, a “master meter” means a single meter used in determining the amount of electricity provided to a multioccupancy building or multiple buildings.

e. This rule shall not be construed to prohibit any utility from requiring more extensive individual metering than otherwise required by this rule if pursuant to tariffs filed with and approved by the board.

f. All electricity consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering, or where metering is impractical.

20.3(2) Condition of meter. Rescinded IAB 11/12/03, effective 12/17/03.

20.3(3) Meter reading records. The meter reading records shall show:

a. Customer’s name, address, and rate schedule or identification of rate schedule.

b. Identification of the meter or meters either by permanently marked utility number or by manufacturer’s name, type number and serial number.

c. Meter readings.

d. If the reading has been estimated.

e. Any applicable multiplier or constant.

20.3(4) Meter charts. Rescinded IAB 12/5/18, effective 1/9/19.

20.3(5) Meter register. If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather-resistant paint upon the front cover of the meter. Customers shall have continuous visual access to meter registers as a means of verifying the accuracy of bills presented to them and for implementing such energy conservation initiatives as they desire, except in the individual locations where the utility has experienced vandalism to windows in the protective enclosures. Where remote meter reading is used, whether outdoor on premises or off premises automated, the customer shall also have readable meter registers at the meter. A utility may comply with the requirements of this subrule by making the required information available via the Internet or other equivalent means.

Where a delayed processing means is used, the utility may comply by having readable kWh registers only, visually accessible.

In instances in which the utility has determined that readable access, to locations existing July 1, 1981, will create a safety hazard, the utility is exempted from the access provisions above.

In instances when a building owner has determined that unrestricted access to tenant metering installation would create a vandalism or safety hazard, the utility is exempted from the access provision above.

Continuing efforts should be made to eliminate or minimize the number of restricted locations. The utility should assist affected customers in obtaining meter register information.

20.3(6) Meter reading and billing interval. Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be provided weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without a waiver from the board. A waiver request must include sufficient information to comply with 199—1.3(17A,474,476). If the board denies a waiver, or if a waiver is not sought with respect to a high-demand customer after the initial month, that customer’s meter shall

be read monthly for the next 12 months. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

An effort shall be made to obtain readings of the meters on corresponding days of each meter reading period. When the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bills shall be prorated on a daily basis.

The utility may permit the customer to supply the meter readings by telephone, by electronic means, or on a form supplied by the utility. The utility may arrange for customer meter reading forms to be delivered to the utility by United States mail, electronically, or by hand delivery. The utility may arrange for the meter to be read by electronic means. Unless the utility has a plan to test check meter readings, a utility representative shall physically read the meter at least once each 12 months.

In the event that the utility leaves a meter reading form with the customer when access to meters cannot be gained and the form is not returned in time for the billing operation, an estimated bill may be provided.

If an actual meter reading cannot be obtained, the utility may provide an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be provided.

20.3(7) Demand meter registration. When a demand meter is used for billing, the meter installation should be designed so that the highest expected annual demand reading to be used for billing will appear in the upper half of the meter's range.

20.3(8) Service areas. Service areas are defined by the boundaries on service area maps. Paper maps are available for viewing during regular business hours at the board's offices and available for purchase at the cost of reproduction. Maps are also available for viewing on the board's website. These service area maps are adopted as part of this rule and are incorporated in this rule by this reference.

20.3(9) Petition for modification of service area and answers. An exclusive service area is subject to modification through a contested case proceeding which may be commenced by filing a petition for modification of service area with the board. The board may commence a service area modification proceeding on its own motion.

Any electric utility or municipal corporation may file a petition for modification of service area which shall contain a legal description of the service area desired, a designation of the utilities involved in each boundary section, and a justification for the proposed service area modification. The justification shall include a detailed statement of why the proposed modification is in the public interest. A map showing the affected areas which complies with paragraph 20.3(11) "a" shall be attached to the petition as an exhibit.

Filing of the petition with the board, and service to other parties, shall be in accordance with 199—Chapter 14.

All parties shall file an answer which complies with 199—subrule 7.5(1).

20.3(10) Certificate of authority. Any electric utility or municipal corporation requesting a service territory modification pursuant to subrule 20.3(9) which would result in service to a customer by a utility other than the utility currently serving the customer must also petition the board for a certificate of authority under Iowa Code section 476.23. The electric utility or municipal corporation shall pay the party currently serving the customer a reasonable price for the facilities serving the customer.

20.3(11) Maps.

a. Each utility shall maintain a current map or set of maps showing the physical location of electric lines, stations, and electric transmission facilities for its service areas. The maps shall include the exact location of the following:

- (1) Generating stations with capacity designation.
- (2) Purchased power supply points with maximum contracted capacity designation.
- (3) Purchased power metering points if located at other than power delivery points.
- (4) Transmission lines with size and type of conductor designation and operating voltage designation.

- (5) Transmission-to-transmission voltage transformation substations with transformer voltage and capacity designation.
- (6) Transmission-to-distribution voltage transformation substations with transformer voltage and capacity designation.
- (7) Distribution lines with size and type of conductor designation, phase designation and voltage designation.
- (8) All points at which transmission, distribution or secondary lines of the utility cross Iowa state boundaries.
- (9) All current information required in Iowa Code section 476.24(1).
- (10) All county boundaries and county names.
- (11) Natural and artificial lakes which cover more than 50 acres and all rivers.
- (12) Any additional information required by the board.

b. All maps, except those deemed confidential by the board, shall be available for examination at the utility's designated offices during the utility's regular office hours. The maps shall be drawn with clean, uniform lines to a scale of one inch per mile. A large scale shall be used where it is necessary to clarify areas where there is a heavy concentration of facilities. All cartographic details shall be clean cut, and the background shall contain little or no coloration or shading.

20.3(12) *Prepayment meters.* Prepayment meters shall not be geared or set so as to result in the charge of a rate or amount higher than would be paid if a standard type meter were used, except under tariffs approved by the board.

20.3(13) *Plant additions, electrical line extensions and service lines.*

a. *Definitions.* The following definitions shall apply to the terms used in this subrule:

"Advance for construction," as used in this subrule, means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or an electrical line extension, portions of which may be refunded depending on the attachment of any subsequent service line made to the extensive plant addition or electrical line extension. Cash payments or equivalent surety shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining tax liability.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in this subrule, means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of a service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Electrical line extensions" means distribution line extensions and secondary line extensions as defined in subrule 20.1(3), except for service lines as defined in this subrule.

"Equivalent overhead transformer cost," as used in this subrule, is that transformer capitalized cost, or fraction thereof, that would be required for similarly situated customers served by a pole-mounted or platform-mounted transformer(s). For each overhead service, it shall be the capitalized cost of the transformer(s) divided by the number of customers served by that transformer(s). For each underground service, it shall be the capitalized cost of an overhead transformer(s) with the same voltage and volt-ampere rating divided by the number of customers served by that transformer(s).

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated base revenues," as used in this subrule, shall be calculated by subtracting the fuel expense costs as described in the uniform system of accounts as adopted by the board and energy efficiency charges from the estimated annual revenues.

“Estimated construction costs,” as used in this subrule, shall be calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the electrical line extension or service line; size, location, and characteristics of the electrical line extension or service line, including appurtenances, except equivalent overhead transformer cost; and whether the ground is frozen or whether other adverse conditions exist. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

“Plant addition,” as used in this subrule, means any additional plant required to be constructed to provide service to a customer other than an electrical line extension or service line.

“Point of attachment” is that point of first physical attachment of the utilities’ service drop (overhead) or service lateral (underground) conductors to the customer’s service entrance conductors. For overhead services it shall be the point of tap or splice to the service entrance conductors. For underground services it shall be the point of tap or splice to the service entrance conductors in a terminal box or meter or other enclosure with adequate space inside or outside the building wall. If there is no terminal box, meter, or other enclosure with adequate space, it shall be the point of entrance into the building.

“Service line,” as used in this subrule, means any secondary line extension, as defined in subrule 20.1(3), on private property serving a single customer or point of attachment of electric service.

“Similarly situated customer,” as used in this subrule, means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

“Utility,” as used in this subrule, means a rate-regulated utility.

b. Plant additions. The utility shall provide all electric plant at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between the utility and the customer which requires an advance for construction by the customer to make plant additions shall be available for board inspection.

c. Electrical line extensions. Where the customer will attach to the electrical line extension within the agreed-upon attachment period after completion of the electrical line extension, the following shall apply:

(1) The utility shall finance and make the electrical line extension for a customer without requiring an advance for construction if the estimated construction costs to provide an electrical line extension are less than or equal to three times estimated base revenue calculated on the basis of similarly situated customers. The utility may use a feasibility model, rather than three times estimated base revenue, to determine what, if any, advance for construction is required by the customer. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility’s tariff. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(2) If the estimated construction cost to provide an electrical line extension is greater than three times estimated base revenue calculated on the basis of similarly situated customers, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction equal to the estimated construction cost less three times estimated base revenue to be produced by the customer. The utility may use a feasibility model to determine whether an advance for construction is required. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility’s tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the electrical line extension would otherwise require a

payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the electrical line extension, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety and shall be refundable for ten years. The customer has the option of providing an advance for construction by cash or equivalent surety unless the utility determines that the customer has failed to comply with the conditions of a surety in the past.

(5) Refunds. When the customer is required to make an advance for construction, the utility shall refund to the depositor for a period of ten years from the date of the original advance a pro-rata share for each service line attached to the electrical line extension. The pro-rata refund shall be computed in the following manner:

1. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension exceeds the total estimated construction cost to provide the electrical line extension, the entire amount of the advance for construction provided shall be refunded.

2. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension is less than the total estimated construction cost to provide the electrical line extension, the amount to be refunded shall equal three times estimated base revenue, or the amount allowed by the feasibility model, when a service line is attached to the electrical line extension.

3. In no event shall the total amount to be refunded exceed the amount of the advance for construction. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

(6) The utility shall keep a record of each work order under which the electrical line extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

d. Service lines.

(1) The utility shall finance and construct either an overhead or underground service line without requiring a nonrefundable contribution in aid of construction or any payment by the applicant where the length of the overhead service line to the first point of attachment is up to 50 feet on private property or where the cost of the underground service line to the meter or service disconnect is less than or equal to the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(2) Where the length of the overhead service line exceeds 50 feet on private property, the applicant shall be required to provide a nonrefundable contribution in aid of construction for that portion of the service line on private property, exclusive of the point of attachment, within 30 days after completion. The nonrefundable contribution in aid of construction for that portion of the service line shall be computed as follows:

(Estimated Construction Costs) ×

$$\frac{\text{(Total Length in Excess of 50 Feet)}}{\text{(Total Length of Service Line)}}$$

(3) Where the cost of the underground service line exceeds the estimated cost of constructing an equivalent overhead service line of up to 50 feet, the applicant shall be required to provide a nonrefundable contribution in aid of construction within 30 days after completion equal to the difference between the estimated cost of constructing the underground service line and the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(4) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet without requiring a nonrefundable contribution in aid of construction from the customer if the tariff or rule applies equally to all customers or members.

(5) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees.

e. Extensions not required. Utilities shall not be required to make electrical line extensions or install service lines as described in this subrule, unless the electrical line extension or service line shall be of a permanent nature. When the utility provides a temporary service to a customer, the utility may require that the customer bear all the cost of installing and removing the service in excess of any salvage realized.

f. Different payment arrangement. This subrule shall not be construed as prohibiting any utility from making a contract with a customer using a different payment arrangement, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among customers.

This rule is intended to implement Iowa Code section 476.8.

[ARC 7584B, IAB 2/25/09, effective 4/1/09; ARC 9501B, IAB 5/18/11, effective 6/22/11; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.4(476) Customer relations.

20.4(1) Customer information. Each utility shall:

a. Maintain up-to-date maps, plans, or records of its entire transmission and distribution systems, together with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving prospective customers in its service area.

b. Assist the customer or prospective customer in selecting the most economical rate schedule available for the customer's proposed type of service.

c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the board. (199—26.5(476))

d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the board, are available for public inspection. If the utility has provided access to its rate schedules and rules for service on its website, the notice shall include the website address.

e. Upon request, inform its customers as to the method of reading meters.

f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office. If the utility provides access to its tariff and rate schedules on its website, the bill form shall include the website address.

g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of electricity for each billing during the prior 12 months.

h. Furnish such additional information as the customer may reasonably request.

20.4(2) Customer contact employee qualifications. Each utility shall promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does

not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, or by writing to 1375 E. Court Avenue, Des Moines, Iowa 50319-0069, or by email to customer@iub.iowa.gov.”

The bill insert or notice for municipal utilities shall include the following statement: “If your complaint is related to service disconnection, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, by writing to 1375 E. Court Avenue, Des Moines, Iowa 50319-0069, or by email to customer@iub.iowa.gov.”

The bill insert or notice for non-rate-regulated rural electric cooperatives shall include the following statement: “If your complaint is related to the (utility name) service rather than its rates, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, by writing to 1375 E. Court Avenue, Des Moines, Iowa 50319-0069, or by email to customer@iub.iowa.gov.”

The bill insert or notice on the bill shall be provided monthly by utilities serving more than 50,000 Iowa retail customers and no less than annually by all other electric utilities. Any utility which does not use the standard statement described in this subrule shall file its proposed statement in its tariff for approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

20.4(3) *Customer deposits.*

a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility shall allow a person other than the customer to pay the customer’s deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.

b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility’s business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place which has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place which has not previously received service, or for an industrial customer, shall be the customer’s projected one-month usage for the place to be served as determined by the utility, or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

20.4(4) *Interest on customer deposits.* Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer’s account, or to the date the customer’s bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer’s last-known address. The date a customer’s bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

20.4(5) *Customer deposit records.* Each utility shall keep records to show:

- a.* The name and address of each depositor.
- b.* The amount and date of the deposit.

c. Each transaction concerning the deposit.

20.4(6) *Customer's receipt for a deposit.* Each utility shall issue a receipt of deposit to each customer from whom a deposit is received, and shall provide means whereby a depositor may establish claim if the receipt is lost.

20.4(7) *Deposit refund.* A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and 1 automatic forgiveness of late payment). For refund purposes the account shall be reviewed for prompt payment after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However, deposits received from customers subject to the exemption provided by 20.4(3) "b," including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

20.4(8) *Unclaimed deposits.* The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

20.4(9) *Customer bill forms.* Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, of the following:

- a. The reading of the meter at the beginning and at the end of the period for which the bill is provided.
- b. The dates on which the meter was read, at the beginning and end of the billing period.
- c. The number and kind of units metered.
- d. The applicable rate schedule, with the identification of the applicable rate classification.
- e. The account balance brought forward and amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.
- f. The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is provided.
- g. A distinct marking to identify an estimated bill.
- h. A distinct marking to identify a minimum bill.
- i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.
- j. Customer billing information alternate. A utility serving less than 5000 electric customers may provide the information in 20.4(9) on bill form or otherwise. If the utility elects not to provide the information of 20.4(9), it shall advise the customer, on bill form or by bill insert, that such information can be obtained by contacting the utility's local office.

20.4(10) Rescinded, effective 7/1/81.

20.4(11) *Payment agreements.*

a. *Availability of a first payment agreement.* When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and is not in default of a payment agreement with the utility, a utility shall offer the customer an opportunity to enter into a reasonable payment agreement.

b. *Reasonableness.* Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of human services or another agency.

c. *Terms of payment agreements.*

(1) First payment agreement. The utility shall offer the following conditions to customers who have received a disconnection notice or who have been previously disconnected and are not in default of a payment agreement:

1. For customers who received a disconnection notice or who have been disconnected less than 120 days and are not in default of a payment agreement, the utility shall offer an agreement with at least 12 even monthly payments. For customers who have been disconnected more than 120 days and are not in default of a payment agreement, the utility shall offer an agreement with at least 6 even monthly payments. The utility shall inform customers they may pay off the delinquency early without incurring any prepayment penalties.

2. The agreement shall also include a provision for payment of the current account.

3. The utility may also require the customer to enter into a budget billing plan to pay the current bill.

4. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

5. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission.

6. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall provide to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement.

7. The document will be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage paid. If delivery is by other than U.S. mail, the document shall be considered provided to the customer when delivered to the last-known address of the person responsible for payment for the service.

8. The document shall state that unless the customer notifies the utility otherwise within ten days from the date the document is provided, it will be deemed that the customer accepts the terms as stated in the written document. The document stating the terms and conditions of the agreement shall include the address and a toll-free or collect telephone number where a qualified representative can be reached.

9. Once the first payment required by the agreement is made by the customer or on behalf of the customer, the oral or electronic agreement is deemed accepted by the customer.

10. Each customer entering into a first payment agreement shall be granted at least one late payment that is four days or less beyond the due date for payment, and the first payment agreement shall remain in effect.

11. The initial payment is due on the due date for the next regular bill.

(2) Second payment agreement. The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement.

1. The second payment agreement shall be for a term at least as long as the term of the first payment agreement.

2. The customer shall be required to pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement.

3. The utility may also require the customer to enter into a budget billing plan to pay the current bill.

(3) Additional payment agreements. The utility may offer additional payment agreements to the customer.

d. Refusal by utility. A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must provide a written refusal to the customer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered provided to the customer when handed to

the customer or when delivered to the last-known address of the person responsible for the payment for the service.

A customer may ask the board for assistance in working out a reasonable payment agreement. The request for assistance must be made to the board within ten days after the written refusal is provided. During the review of this request, the utility shall not disconnect the service.

20.4(12) Bill payment terms. The bill shall be considered provided to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered provided when delivered to the last-known address of the party responsible for payment. There shall not be less than 20 days between the providing of a bill and the date by which the account becomes delinquent. Bills for customers on more frequent billing intervals under subrule 20.3(6) may not be considered delinquent less than 5 days from the date the bill is provided. However, a late payment charge may not be assessed if payment is received within 20 days of the date the bill is provided.

a. The date of delinquency for all residential customers or other customers whose consumption is less than 3,000 kWh per month shall be changeable for cause; such as, but not limited to, 15 days from approximate date each month upon which income is received by the person responsible for payment. In no case, however, shall the utility be required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

b. In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

c. If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

d. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

e. Budget billing plan. Utilities shall offer a budget billing plan to all residential customers or other customers whose consumption is less than 3,000 kWh per month. A budget billing plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The budget billing plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service. The plan may be estimated if there is insufficient usage history to create a budget billing plan based on actual use.

(2) Allow for entry into the budget billing plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new budget billing plan to a customer for six months after the customer has terminated from a budget billing plan.

(4) Use a computation method that produces a reasonable monthly budget billing amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements of this subrule. The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the budget billing plan.

The amount to be paid at each billing interval by a customer on a budget billing plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The budget billing amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price,

consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the budget billing amount is recomputed, the budget billing plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly budget billing amount. Except when a utility has a budget billing plan that recomputes the budget billing amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' budget billing amounts due or of obtaining a refund of any credit in excess of \$25.

Except when a utility has a budget billing plan that recomputes the budget billing amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing period prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the budget billing amount. If the account balance is a credit, the budget billing plan may be terminated by the utility after 30 days of delinquency.

20.4(13) Customer records. The utility shall retain records as may be necessary to effectuate compliance with 20.4(14) and 20.6(6), but not less than five years. Records for customer shall show where applicable:

- a. kWh meter reading.
- b. kWh consumption.
- c. kW meter reading.
- d. kW measured demand.
- e. kW billing demand.
- f. Total amount of bill.

20.4(14) Adjustment of bills.

a. *Meter error.* Whenever a meter creeps or whenever a metering installation is found upon any test to have an average error of more than 2.0 percent for watt-hour metering; or a demand metering error of more than 1.5 percent in addition to the errors allowed under accuracy of demand metering; an adjustment of bills for service for the period of inaccuracy shall be made in the case of overregistration and may be made in the case of underregistration. The amount of the adjustment shall be calculated on the basis that the metering equipment should be 100 percent accurate with respect to the testing equipment used to make the test. For watt-hour metering installations the average accuracy shall be the arithmetic average of the percent registration at 10 percent of rated test current and at 100 percent of rated test current giving the 100 percent of rated test current registration a weight of four and the 10 percent of rated test current registration a weight of one.

b. *Determination of adjustment.* Recalculation of bills shall be on the basis of actual monthly consumption except that if service has been measured by self-contained single-phase meters or three-wire network meters and involves no billing other than for kilowatt-hours, the recalculation of bills may be based on the average monthly consumption determined from the most recent 36 months, consumption data.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, it shall be permissible to use the registration of check metering installations, if any, or to estimate the quantity of energy consumed based on available data. The customer must be advised of the failure and of the basis for the estimate of quantity billed. The periods of error shall be used as defined in immediately following subparagraphs (1) and (2).

(1) *Overregistration.* If the date when overregistration began can be determined, such date shall be the starting point for determination of the amount of the adjustment. If the date when overregistration began cannot be determined, it shall be assumed that the error has existed for the shortest time period calculated as one-half the time since the meter was installed, or one-half the time elapsed since the last meter test unless otherwise ordered by the board.

The overregistration due to creep shall be calculated by timing the rate of creeping and assuming that the creeping affected the registration of the meter for 25 percent of the time since the more recent of either metering installation or last previous test.

(2) Underregistration. If the date when underregistration began can be determined, it shall be the starting point for determination of the amount of the adjustment except that billing adjustment shall be limited to the preceding six months. If the date when underregistration began cannot be determined, it shall be assumed that the error has existed for one-half of the time elapsed since the more recent of either meter installation or the last meter test, except that billing adjustment shall be limited to the preceding six months unless otherwise ordered by the board.

The underregistration due to creep shall be calculated by timing the rate of creeping and assuming that this creeping affected the registration for 25 percent of the time since the more recent of either metering installation or last previous test, except that billing adjustment shall be limited to the preceding six months.

c. Refunds. If the recalculated bills indicate that \$5 or more is due an existing customer or \$10 or more is due a person no longer a customer of the utility, the tariff shall provide refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be made to the two most recent customers who received service through the metering installation found to be in error. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

d. Back billing. A utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than, but may be greater than, \$5 for an existing customer or \$10 for a former customer. All recalculations resulting in an amount due equal to or greater than the tariff specified minimum shall result in issuance of a back bill.

Back billings shall be provided no later than six months following the date of the metering installation test.

e. Overcharges. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the metering installation or other similar reasons, the amount of the overcharge shall be adjusted, refunded or credited to the customer. The time period for which the utility is required to adjust, refund, or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

f. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the board. The maximum back bill shall not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

g. Credits and explanations. Credits due a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

20.4(15) Refusal or disconnection of service. A utility shall refuse service or disconnect service to a customer, as defined in subrule 20.1(3), in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 20.4(15) "b." The notice shall set forth the reason for the notice and the final date by which the account is to be settled or specific action taken. The notice shall be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered provided when delivered to the last-known address of the person responsible for payment for the service. The date for disconnection of service shall be not less than 12 days after the notice is provided. The date for disconnection of service

for customers on shorter billing intervals under subrule 20.3(6) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

b. Service may be disconnected without notice:

(1) In the event of a condition on the customer's premises determined by the utility to be hazardous.
 (2) In the event of customer use of equipment in a manner which adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.

(4) In the event of unauthorized use.

c. Service may be disconnected or refused after proper notice:

(1) For violation of or noncompliance with the utility's rules on file with the board.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way which are specified to be furnished, in the utility's rules filed with the board, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the board.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 20.4(16) and 20.4(17), provided that the utility has complied with the following provisions when applicable:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal.

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently than monthly pursuant to subrule 20.3(6) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) The summary of the rights and responsibilities must be approved by the board. Any utility providing electric service and defined as a public utility in Iowa Code section 476.1 which does not use the standard form set forth below for customers billed monthly shall submit to the board electronically its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "electric" with the words "gas and electric" in all instances.

CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF ELECTRIC SERVICE FOR NONPAYMENT

1. What can I do if I receive a notice from the utility that says my service will be shut off because I have a past due bill?

- a. Pay the bill in full; or
- b. Enter into a reasonable payment plan with the utility (see #2 below); or
- c. Apply for and become eligible for low-income energy assistance (see #3 below); or
- d. Give the utility a written statement from a doctor or public health official stating that shutting off your electric service would pose an especial health danger for a person living at the residence (see #4 below); or

e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

2. How do I go about making a reasonable payment plan? (Residential customers only)

a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

3. How do I apply for low-income energy assistance? (Residential customers only)

a. Contact the local community action agency in your area (see attached list) or visit humanrights.iowa.gov/dcaa/where-apply.

b. To avoid disconnection, you must apply for energy assistance or weatherization before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

c. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1.

d. If you have additional questions, contact the Division of Community Action Agencies at the Iowa Department of Human Rights, Lucas State Office Building, Des Moines, Iowa 50319; telephone (515)281-3861.

4. What if someone living at the residence has a serious health condition? (Residential customers only)

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within 5 days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

5. What should I do if I believe my bill is not correct?

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Board for assistance in resolving the dispute. (See #9 below.)

6. When can the utility shut off my utility service because I have not paid my bill?

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.
b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, utility service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the utility must be informed of the deployment prior to disconnection. However, you will still owe the utility for service used during this time.

7. How will I be told the utility is going to shut off my service?

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door or another conspicuous place at your residence to tell you that your utility service will be shut off.

8. If service is shut off, when will it be turned back on?

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan (see #2 above).

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. Those fees may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

9. Is there any other help available besides my utility?

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Board toll-free at 1-877-565-4450. You may also write the Iowa Utilities Board at 1375 E. Court Avenue, Des Moines, Iowa 50319-0069, or by E-mail at customer@iub.iowa.gov. Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 1-800-532-1275.

(4) If the utility has adopted a service limitation policy pursuant to subrule 20.4(23), the following paragraph shall be appended to the end of the standard form for the summary of rights and responsibilities, as set forth in subparagraph 20.4(15)“d”(3):

Service limitation: We have adopted a limitation of service policy for customers who otherwise could be disconnected. Contact our business office for more information or to learn if you qualify.

(5) When disconnecting service to a residence, made a diligent attempt to contact, by telephone or in person, the customer responsible for payment for service to the residence to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the utility shall make a diligent attempt to contact the landlord of the rental unit, if known, to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected. The utility shall make a diligent attempt to inform the landlord at least 48 hours prior to disconnection of service to a tenant.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted, at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(6) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for electric utility service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of

service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the providing of the bill if the customer pays the undisputed amount. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board in compliance with 199—Chapter 6.

(7) Reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(8) Severe cold weather. A disconnection may not take place where electricity is used as the only source of space heating or to control or operate the only space heating equipment at a residence when the actual temperature or the 24-hour forecast of the National Weather Service for the residence's area is predicted to be 20 degrees Fahrenheit or colder. If the utility has properly posted a disconnect notice but is precluded from disconnecting service because of severe cold weather, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the residence's area rises above 20 degrees Fahrenheit and is forecasted to remain above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is otherwise entitled to postponement of disconnection.

(9) Health of a resident. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to: age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances which indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 20.4(15) "f."

(10) Winter energy assistance (November 1 through April 1). If the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program. A utility may develop an incentive program to delay disconnection on April 1 for customers who make payments throughout the November 1 through April 1 period. All such incentive programs shall be set forth in tariffs approved by the board.

(11) Deployment. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

e. Abnormal electric consumption. A customer who is subject to disconnection for nonpayment of bill, and who has electric consumption which appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of electric usage which may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance which may be available to the customer.

f. A utility may disconnect electric service after 24-hour notice (and without the written 12-day notice) for failure of the customer to comply with the terms of a payment agreement.

g. The utility shall, prior to November 1, mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and must contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

20.4(16) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a customer:

- a.* Delinquency in payment for service by a previous occupant of the premises to be served.
- b.* Failure to pay for merchandise purchased from the utility.
- c.* Failure to pay for a different type or class of public utility service.
- d.* Failure to pay the bill of another customer as guarantor thereof.
- e.* Failure to pay the back bill provided in accordance with paragraph 20.4(14) "d" (slow meters).
- f.* Failure to pay a bill provided in accordance with paragraph 20.4(14) "f."
- g.* Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service in the customer's name.
- h.* Delinquency in payment for service by an occupant if the customer applying for service is creditworthy and able to satisfy any deposit requirements.
- i.* Delinquency in payment for service arising more than ten years prior, as measured from the most recent of:
 - (1) The last date of service for the account giving rise to the delinquency,
 - (2) Physical disconnection of service for the account giving rise to the delinquency, or
 - (3) The last voluntary payment or voluntary written promise of payment made by the customer, if made before the ten-year period described in this paragraph has otherwise lapsed.
- j.* Delinquency in payment for service that arose on or before September 4, 2010, pursuant to an oral contract, except in cases of fraud or deception that prevented the utility from timely addressing such delinquencies with the customer.

20.4(17) *When disconnection prohibited.*

a. No disconnection may take place from November 1 through April 1 for a resident who has been certified to the public utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

20.4(18) *Estimated demand.* Upon request of the customer and provided the customer's demand is estimated for billing purposes, the utility shall measure the demand during the customer's normal operation and use the measured demand for billing.

20.4(19) *Servicing utilization control equipment.* Each utility shall service and maintain any equipment it uses on customer's premises and shall correctly set and keep in proper adjustment any thermostats, clocks, relays, time switches or other devices which control the customer's service in accordance with the provisions in the utility's rate schedules.

20.4(20) Customer complaints. Complaints concerning the charges, practices, facilities or service of the utility shall be investigated promptly and thoroughly. The utility shall keep such records of customer complaints as will enable it to review and analyze its procedures and actions.

a. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of customer complaints.

b. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

c. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

20.4(21) Temporary service. Rescinded IAB 12/5/18, effective 1/9/19.

20.4(22) Change in type of service. If a change in the type of service or a change in voltage to a customer's substation is effected at the insistence of the utility and not solely by reason of increase in the customer's load or change in the character thereof, the utility shall share equitably in the cost of changing the equipment of the customer affected as determined by the board in the absence of agreement between utility and customer. In general, the customer should be protected against or reimbursed for the following losses and expenses to an appropriate degree:

a. Loss of value in electrical power utilization equipment.

b. Cost of changes in wiring, and

c. Cost of removing old and installing new utilization equipment.

20.4(23) Limitation of service. The utility shall have the option of adopting a policy for service limitation at a customer's residence as a measure to be taken in lieu of disconnection of service to the customer. The service limiter policy shall be set out in the utility's tariff and shall contain the following conditions:

a. A service limitation device shall not be activated without the customer's agreement.

b. A service limitation device shall not be activated unless the customer has defaulted on all payment agreements for which the customer qualifies under the board's rules and the customer has agreed to a subsequent payment agreement.

c. The service limiter shall provide for usage of a minimum of 3,600 watts. If the service limiter policy provides for different usage levels for different customers, the tariff shall set out specific nondiscriminatory criteria for determining the usage levels. Electric-heating residential customers may have their service limited if otherwise eligible, but such customers shall have consumption limits set at a level that allows them to continue to heat their residences. For purposes of this rule, "electric heating" shall mean heating by means of a fixed-installation electric appliance that serves as the primary source of heat and not, for example, one or more space heaters.

d. A provision that, if the minimum usage limit is exceeded such that the limiter function interrupts service, the service limiter function must be capable of being reset manually by the customer, or the service limiter function must reset itself automatically within 15 minutes after the interruption. In addition, the service limiter function may also be capable of being reset remotely by the utility. If the utility chooses to use the option of resetting the meter remotely, the utility shall provide a 24-hour toll-free number for the customer to notify the utility that the limiter needs to be reset and the meter shall be reset immediately following notification by the customer. If the remote reset option is used, the meter must still be capable of being reset manually by the customer or the service limiter function must reset itself automatically within 15 minutes after the interruption.

e. There shall be no disconnect, reconnect, or other charges associated with service limiter interruptions or restorations.

f. A provision that, upon installation of a service limiter or activation of a service limiter function on the meter, the utility shall provide the customer with information on the operation of the limiter, including how it can be reset, and information on what appliances or combination of appliances can generally be operated to stay within the limits imposed by the limiter.

g. A provision that the service limiter function of the meter shall be disabled no later than the next working day after the residential customer has paid the delinquent balance in full.

h. A service limiter customer that defaults on the payment agreement is subject to disconnection after a 24-hour notice pursuant to paragraph 20.4(15)“*f.*”

[ARC 7976B, IAB 7/29/09, effective 9/2/09; ARC 9101B, IAB 9/22/10, effective 10/27/10; Editorial change: IAC Supplement 12/29/10; ARC 4171C, IAB 12/5/18, effective 1/9/19]

These rules are intended to implement Iowa Code sections 476.6, 476.8, 476.20 and 476.54.

199—20.5(476) Engineering practice.

20.5(1) Requirement for good engineering practice. The electric plant of the utility shall be constructed, installed, maintained and operated in accordance with accepted good engineering practice in the electric industry to assure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

20.5(2) Standards incorporated by reference. The utility shall use the applicable provisions in the publications listed below as standards of accepted good practice unless otherwise ordered by the board.

- a.* Iowa Electrical Safety Code, as defined in 199—Chapter 25.
- b.* National Electrical Code, ANSI/NFPA 70-2014.
- c.* American National Standard Requirements for Instrument Transformers, ANSI/IEEE C57.13.1-2006; and C57.13.3-2005.
- d.* American National Standard for Electric Power Systems and Equipment Voltage Ratings (60 Hertz), ANSI C84.1-2011.
- e.* Grounding of Industrial and Commercial Power Systems, IEEE 142-2007.
- f.* IEEE Standard 1159-2009, IEEE Recommended Practice for Monitoring Electric Power Quality or any successor standard.
- g.* IEEE Standard 519-2014, IEEE Recommended Practices and Requirements for Harmonic Control in Electrical Power Systems or its successor standard.
- h.* At railroad crossings, 199—42.6(476), “Engineering standards for electric and communications lines.”

20.5(3) Adequacy of supply and reliability of service. The generating capacity of the utility’s plant, supplemented by the electric power regularly available from other sources, must be sufficiently large to meet all normal demands for service and provide a reasonable reserve for emergencies.

In appraising adequacy of supply the board will segregate electric utilities into two classes viz., those having high capacity transmission interconnections with other electrical utilities and those which lack such interconnection and are therefore completely dependent upon the firm generating capacity of the utility’s own generating facilities.

a. In the case of utilities having interconnecting ties with other utilities, the board will, upon appraising adequacy of supply, take appropriate notice of the utility’s recent past record, as of the date of appraisal, of any widespread service interruptions and any capacity shortages along with the consideration of the supply regularly available from other sources, the normal demands, and the required reserve for emergencies.

b. In the case of noninterconnected utilities the board will give attention to the maximum total coincident customer demand which could be satisfied without the use of the single element of plant equipment, the disability of which would produce the greatest reduction in total net plant productive capacity and also give attention to the normal demands for service and to the reasonable reserve for emergencies.

20.5(4) Electric transmission and distribution facilities. Rescinded IAB 11/13/02, effective 12/18/02.

20.5(5) Inspection of electric plant. Rescinded IAB 12/5/18, effective 1/9/19.

This rule is intended to implement Iowa Code section 476.8 and 478.18.

[ARC 7962B, IAB 7/15/09, effective 8/19/09; ARC 9501B, IAB 5/18/11, effective 6/22/11; ARC 1359C, IAB 3/5/14, effective 4/9/14; ARC 2711C, IAB 9/14/16, effective 10/19/16; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.6(476) Metering.

20.6(1) Inspection and testing program. Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The

frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The publications listed in 20.6(3) are representative of accepted good practice. Each utility shall maintain inspecting and testing records for each meter and associated device until three years after its retirement.

20.6(2) Program content. The written program shall, at minimum, address the following subject areas:

- a. Classification of meters by capacity, type, and any other factor considered pertinent.
- b. Checking of new meters for acceptable accuracy before being placed in service.
- c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments or repairs. This may be accomplished by periodic tests at specified intervals or on the basis of a statistical sampling plan, but shall include meters removed from service for any reason.
- d. Periodic calibration or testing of devices or instruments used by the utility to test meters.
- e. The limits of meter accuracy considered acceptable by the utility.
- f. The nature of meter and meter test records which will be maintained by the utility.

20.6(3) Accepted good practice. The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

- a. American National Standard Code for Electricity Metering, ANSI C12.1-2014.
- b. and c. Rescinded IAB 5/23/07, effective 6/27/07.

20.6(4) Meter adjustment. All meters and associated metering devices shall, when tested, be adjusted as closely as practicable to the condition of zero error.

20.6(5) Request tests. Upon request by a customer, a utility shall test the meter servicing that customer. A test need not be made more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer \$25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

20.6(6) Referee tests. Upon written request by a customer or utility, the board will conduct a referee test of a meter. A test need not be made more frequently than once in 18 months. The customer request shall be accompanied by a \$30 deposit in the form of a check or money order made payable to the utility.

Within five days of receipt of the written request and payment, the board shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after notification of the request, schedule the date, time and place of the test with the board and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments shall be made as required in 20.4(14). The board shall issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

20.6(7) Condition of meter. No meter that is known to be mechanically or electrically defective, or to have incorrect constants, or that has not been tested and adjusted if necessary in accordance with these rules shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the electricity requirements of the customer.

20.6(8) Comprehensive meter upgrade programs.

a. A utility may forgo the meter testing procedures required under the utility's own inspection and testing program and subrule 20.6(2) if:

- (1) The meters are removed or scheduled to be removed as part of a comprehensive meter upgrade program over a specified period not to exceed three years;
- (2) The meters being removed have not previously been shown to be inaccurate or otherwise faulty;
- (3) The utility either retains the removed meters for a period of one year from the removal date to allow customers the opportunity to challenge a meter's accuracy or tests a representative statistical

sample based upon an industry standard such as ANSI C12.1-2014 of each type of meter being removed as part of the program and maintains the removed meters for a period of at least six months; and

(4) The utility tests any meter upon request of a customer based upon the customer's experience comparing the replaced and replacement meters.

b. Prior to forgoing its testing procedures under this subrule, a utility shall notify the board that the utility is engaging in a comprehensive meter upgrade program. The notice shall state the option the utility is electing to pursue under subparagraph 20.6(8) "a"(3), the specified period of the program, and the expected number of meters to be upgraded. A utility electing to test a statistical sample of removed meters under subparagraph 20.6(8) "a"(3) shall also state the industry standard it will use to determine the sample size and provide the full text of the standard to the board upon request.

c. A utility shall continue to follow the meter testing procedures for meters removed for any reason unrelated to the comprehensive meter upgrade program.

d. A utility shall resume the meter testing procedures required under the utility's own inspection and testing program and subrule 20.6(2) upon completion of the comprehensive meter upgrade program or the end of the specified period, whichever occurs first.

[ARC 7962B, IAB 7/15/09, effective 8/19/09; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.7(476) Standards of quality of service.

20.7(1) Standard frequency. The standard frequency for alternating current distribution systems shall be 60 cycles per second. The frequency shall be maintained within limits which will permit the satisfactory operation of customer's clocks connected to the system.

20.7(2) Voltage limits retail. Each utility supplying electric service to ultimate customers shall provide service voltages in conformance with the standard at 20.5(2) "d."

20.7(3) Voltage balance. Where three-phase service is provided the utility shall exercise reasonable care to assure that the phase voltages are in balance. In no case shall the ratio of maximum voltage deviation from average to average voltage exceed .02.

20.7(4) Voltage limits, service for resale. The nominal voltage shall be as mutually agreed upon by the parties concerned. The allowable variation shall not exceed 7.5 percent above or below the agreed-upon nominal voltage without the express approval of the board.

20.7(5) Exceptions to voltage requirements. Voltage outside the limits specified will not be considered a violation when the variations:

- a.* Arise from the action of the elements.
- b.* Are infrequent fluctuations not exceeding five minutes, duration.
- c.* Arise from service interruptions.
- d.* Arise from temporary separation of parts of the system from the main system.
- e.* Are from causes beyond the control of the utility.
- f.* Do not exceed 10 percent above or below the standard nominal voltage, and service is at a distribution line or transmission line voltage with the retail customer providing voltage regulators.

20.7(6) Voltage surveys and records. Voltage measurements shall be made at the customer's entrance terminals. For single-phase service the measurement shall be made between the grounded conductor and the ungrounded conductors. For three-phase service the measurement shall be made between the phase wires.

20.7(7) Each utility shall make a sufficient number of voltage measurements in order to determine if voltages are in compliance with the requirements as stated in 20.7(2), 20.7(3), and 20.7(4). All records obtained under this subrule shall be retained by the utility for at least two years and shall be available for inspection by the board's representatives. Notations on each chart shall indicate the following:

- a.* The location where the voltage was taken.
- b.* The time and date of the test.
- c.* The results of the comparison with a working standard indicating voltmeter.

20.7(8) Equipment for voltage measurements.

a. Secondary standard indicating voltmeter. Each utility shall have available at least one indicating voltmeter maintained with error no greater than 0.25 percent of full scale.

b. Working standard indicating voltmeters. Each utility shall have at least two indicating voltmeters maintained so as to have as-left errors of no greater than 1 percent of full scale.

c. Recording voltmeters. Each utility must have readily available at least two portable recording voltmeters with a rated accuracy of 1 percent of full scale.

20.7(9) Rescinded IAB 12/11/91, effective 1/15/92.

20.7(10) Extreme care must be exercised in the handling of standards and instruments to assure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

20.7(11) Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers, and interruptions planned for longer than one hour shall be preceded by adequate notice to those who will be affected.

20.7(12) Power quality monitoring. Each utility shall investigate power quality complaints from its customers and determine if the cause of the problem is on the utility's systems. In addressing these problems, each utility shall implement to the extent reasonably practical the practices outlined in the standard given at 20.5(2) "f."

20.7(13) Harmonics. A harmonic is a sinusoidal component of the 60 cycles per second fundamental wave having a frequency that is an integral multiple of the fundamental frequency. When excessive harmonics problems arise, each electric utility shall investigate and take actions to rectify the problem. In addressing harmonics problems, the utility and the customer shall implement to the extent practicable and in conformance with prudent operation the practices outlined in the standard at 20.5(2) "g."

This rule is intended to implement Iowa Code sections 476.2 and 476.8.
[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.8(476) Safety.

20.8(1) *Protective measures.* Each utility shall exercise reasonable care to reduce those hazards inherent in connection with its utility service and to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public and fitted to the size and type of its operations.

20.8(2) *Accident investigation and prevention.* The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

20.8(3) *Reportable accidents.* Each utility shall maintain a summary of all reportable accidents, as defined in 199—25.5(476,478), arising from its operations.

20.8(4) *Grounding of secondary distribution system.* Unless otherwise specified by the board, each utility shall comply with, and shall encourage its customers to comply with, the applicable provisions of the acceptable standards listed in 20.5(2) for the grounding of secondary circuits and equipment.

Ground connections should be tested for resistance at the time of installation. The utility shall keep a record of all ground resistance measurements.

The utility shall establish a program of inspection so that all artificial grounds installed by it shall be inspected within reasonable periods of time.

199—20.9(476) Electric energy sliding scale or automatic adjustment. A rate-regulated utility's sliding scale or automatic adjustment of the unit charge for electric energy shall be an energy clause.

20.9(1) *Applicability.* A rate-regulated utility's sliding scale or automatic adjustment of electric utility energy rates shall recover from consumers only those costs which:

Are incurred in supplying energy;

Are beyond direct control of management;

Are subject to sudden important change in level;

Are an important factor in determining the total cost to serve; and

Are readily, precisely, and continuously segregated in the accounts of the utility.

20.9(2) Energy clause for rate-regulated utility. Prior to each billing cycle, a rate-regulated utility shall determine and file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The estimated amount of fossil fuel should be detailed to reflect the amount of fuel, transportation, and other costs.

The journal entries should reflect the following breakdown for each type of fuel: actual cost of fuel, transportation, and other costs. Items identified as other costs should be described and their inclusion as fuel costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and
2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.
 - a. The energy adjustment shall provide for change of the price per kilowatt hour consumed under rates set by the board based upon the formulas provided below. The calculation shall be:

$$E_0 = \frac{EC_0 + EC_1}{EQ_0 + EQ_1} + \frac{A_1}{EJ_0 + EJ_1} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

EC_0 is the estimated expense for energy in the month during which E_0 will be used.

EC_1 is the estimated expense for energy in the month prior to the month of EC_0 .

EQ_0 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered into account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month in which E_0 will be used.

EQ_1 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month prior to EQ_0 .

EJ_0 is the estimated electric energy to be consumed under rates set by the board in the month during which the energy adjustment charge (E_0) will be used in bill calculations.

EJ_1 is the estimated electric energy to be consumed under rates set by the board in the month prior to the month of EJ_0 .

A_1 is the beginning of the month energy cost adjustment account balance for the month of estimated consumption EJ_1 . This would be the most recent month's balance available from actual accounting data.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. The estimated energy cost ($EC_0 + EC_1$) shall be the estimated cost associated with EQ_0 and EQ_1 determined as the cost of:

- (1) Fossil and nuclear fuel consumed in the utility's own plants and the utility's share of fossil and nuclear fuel consumed in jointly owned or leased plants. Fossil fuel shall include natural gas used for electric generation and the cost of fossil fuel transferred from account 151 to account 501 or 547 of the Uniform System of Accounts for Electric Utilities. Nuclear fuel shall be that shown in account 518 of the Uniform System of Accounts except that if account 518 contains any expense for fossil fuel which has already been included in the cost of fossil fuel, it shall be deducted from the account. (Paragraph C of account 518 includes the cost of other fuels used for ancillary steam facilities.)

(2) The cost of steam purchased, or transferred from another department of the utility or from others under a joint facility operating agreement, for use in prime movers producing electric energy (accounts 503 and 521).

(3) A deduction shall be made of the expenses of producing steam chargeable to others, to other utility departments under a joint operating agreement, or to other electric accounts outside the steam generation group of accounts (accounts 504 and 522).

(4) The cost of water used for hydraulic power generation. Water cost shall be limited to items of account 536 of the Uniform System of Accounts. For pumped storage projects the energy cost of pumping is included. Pumping energy cost shall be determined from the applicable costs of subparagraphs of paragraph 20.9(2) "b."

(5) The energy costs paid for energy purchased under arrangements or contracts for capacity and energy, as entered into account 555 of the Uniform System of Accounts, less the energy revenues to be recovered from corresponding sales, as entered in account 447 of the Uniform System of Accounts.

(6) Purchases from AEP facilities under rule 199—15.11(476).

(7) The weighted average costs of inventoried allowances used in generating electricity.

(8) The gains and losses, as described in subrule 20.17(9), from allowance transactions occurring during the month. Allowance transactions shall include vintage trades and emission for emission trades.

(9) Eligible costs or credits associated with the utility's annual reconciliation of its alternate energy purchase program under 199—paragraph 15.17(4) "b."

c. The energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board. Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the actual expense for energy, calculated as set forth in 20.9(2) "b," in the month prior to EJ_1 of 20.9(2) "a."

J_2 is the actual energy consumed in the prior month under rates set by the board and recorded in accounts 440, 442 and 444-6 of the Uniform System of Accounts.

Q_2 is the actual total energy consumed or delivered in the prior month and recorded in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447, and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. Reserve account for nuclear generation. A rate-regulated utility owning nuclear generation or purchasing energy under a participation power agreement on nuclear generation may establish a reserve account. The reserve account will spread the higher cost of energy used to replace that normally received from nuclear sources. A surcharge would be added to each kilowatt hour from the nuclear source. The surcharges collected are credited to the reserve account. During an outage or reduced level of operation, replacement energy cost would be offset through debit to the reserve account. The debit would be based upon the cost differential between replacement energy cost and the average cost (including the surcharge) of energy from the nuclear capacity. A reserve account shall have credit and debit limitations equal in dollar amounts to the total cost differential for replacement energy during a normal refueling outage.

e. A rate-regulated utility desiring to collect expensed allowance costs and the gains and losses from allowance transactions through the energy adjustment must file with the board monthly reports including:

(1) The number and weighted average unit cost of allowances used during the month to offset emissions from the utility's affected units;

- (2) The number and unit price of allowances purchased during the month;
- (3) The number and unit price of allowances sold during the month;
- (4) The weighted average unit cost of allowances remaining in inventory;
- (5) The dollar amount of any gain from an allowance sale occurring during the month;
- (6) The dollar amount of any loss from an allowance sale occurring during the month; and
- (7) Documentation of any gain or loss from an allowance sale occurring during the month.

f. A rate-regulated utility which proposes a new sliding scale or automatic adjustment clause of electric utility energy rates shall conform such clause with the rules.

20.9(3) Optional energy clause for a rate-regulated utility which does not own generation. A rate-regulated utility which does not own generation may adopt the energy adjustment clause of this subrule in lieu of that set forth in subrule 20.9(2). Prior to each billing cycle, the rate-regulated utility shall determine and file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The items identified as other costs should be described and their inclusion as energy costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and
2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.

a. The energy adjustment charge shall provide for change of the price per kilowatt-hour consumed to equal the average cost per kilowatt hour delivered by the utility's system. The calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2 , C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2 , Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2 , C_3 and C_4 were incurred.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. A utility purchasing its total electric energy requirements may establish an energy cost adjustment account for which the cumulative balance is the excess or deficiency arising from the difference between commission-recognized energy cost recovery and the amount recovered through application of energy charges on jurisdictional consumption.

For a utility electing to use an energy cost adjustment account the calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} + \frac{A_2}{J_2 + J_3 + J_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2 , C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2 , Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2 , C_3 and C_4 were incurred.

A_2 is the end of the month energy cost adjustment account balance for the month of consumption J_2 . This would be the most recent month's balance available from actual accounting data.

J_2 , J_3 and J_4 are electric energy consumed under rates set by the board in the months corresponding to C_2 , C_3 and C_4 .

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

c. The end of the month energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board.

Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the prior month charges by the wholesale suppliers as recorded in account 555 of the Uniform System of Accounts offset by energy revenues from distinct interchange deliveries entered in account 447.

J_2 is the electric energy consumed under jurisdictional rates in the prior month.

Q_2 is the electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 in the prior month.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. A utility with special conditions may petition the board for a waiver which would recognize its unique circumstances.

e. A utility which does not own generation and proposes a new sliding scale or automatic adjustment clause of electric utility rates shall conform such clause with the rules.

20.9(4) Review of energy clause. At least biennially, but no more than annually, the board will require each utility that owns generation and utilizes an energy adjustment clause to provide fuel, freight, and transportation invoices from two months of the previous calendar year. The board will notify each utility by May 1 as to which two months' invoices will be required. Two copies of these invoices shall be filed with the board no later than the subsequent November 1.

This rule is intended to implement Iowa Code section 476.6(12).
[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.10(476) Ratemaking standards.

20.10(1) Coverage. Standards for ratemaking shall apply to all rate-regulated utilities in the state of Iowa. The board may, by rule or by order in specific cases, exempt a utility or class of utilities from any or all ratemaking standards. The standards are recommended to all service-regulated utilities in this jurisdiction.

20.10(2) Cost of service. Rates charged by an electric utility for providing electric service to each class of electric consumers shall be designed, to the maximum extent practicable, to reasonably reflect the costs of providing electric service to the class. The methods used to determine class costs of service shall to the maximum extent practical permit identification of differences in cost-incurrence, for each class of

electric consumers, attributable to daily and seasonal time of use of service, and permit identification of differences in cost-incurrence attributable to differences in demand, energy, and customer components of cost.

The design of rates should reasonably approximate a pricing methodology for any individual utility that would reflect the price system that would exist in a competitive market environment. For purposes of determining revenue requirements among customer classes, embedded costs shall be preferred. For purposes of determining rate designs within customer classes, long-run marginal cost approaches are preferred although embedded cost approaches may be considered reasonable.

Nothing in this rule shall authorize or require the recovery by an electric utility of revenues in excess of, or less than, the amount of revenues otherwise determined to be lawful by the board.

Guidelines for use in evaluating the acceptability of methods of class cost of service estimation include, but are not limited to, the following:

a. All usage of customer, demand, and energy components of service shall be considered new usage.

b. Customer classes shall be established on the primary basis of reasonably similar usage patterns within classes, even if this requires disaggregation or recombination of traditional customer classes.

c. Generating capacity estimates or allocations among and within classes shall recognize that utility systems are designed to serve both peak and off-peak demand, and shall attribute costs based upon both peak period demand and the contribution of off-peak period demand in determining generation mix. Generating capacity estimates and allocations among and within classes shall be based on load data for each class as described in 199—subrule 35.9(2).

d. Transmission and distribution capacity estimates or allocations among and within classes shall be demand-related based upon system usage patterns, and the load imposed by a class on the transmission or distribution capacity in question.

e. Customer cost component estimates or allocations shall include only costs of the distribution system from and including transformers, meters and associated customer service expenses.

f. Methods of cost estimates or allocations among customer classes shall recognize the differences in voltage levels and other service characteristics, and line losses among customer classes.

g. Methods of class cost of service determination which are consistent with zero customer, demand, or energy component costs or major categories of these, such as generation, transmission or distribution, shall be considered unacceptable methods.

h. Long-run marginal cost methods of class cost of service determination shall clearly reflect changes in total costs to the utility with respect to changes in the outputs of customer, demand, or energy components of electric services.

i. The use of an inverse elasticity approach to adjust long-run marginal cost-based rates to the revenue requirement shall be unacceptable. Other approaches will be considered on a case-by-case basis.

20.10(3) Declining block rates. The energy-related cost component of a rate, or the amount attributable to the energy-related cost component of a rate, charged by an electric utility for providing electric service during any period to any class of electric consumers, shall not decrease as kilowatt-hour consumption by such class increases during the period except to the extent that the utility demonstrates that the energy costs of providing electric service to such class decrease as consumption increases during the period.

20.10(4) Time-of-day rates. The rates charged by any electric utility for providing electric service to each class of electric consumers shall be on a time-of-day basis which reflects the cost of providing electric service to that class of electric consumers at different times of the day unless such rates are not cost-effective with respect to the class. These rates are cost-effective with respect to a class if the long-run benefits of the rate to the electric utility and its electric consumers in the class concerned are likely to exceed the metering costs and other costs associated with the use of the rates. Cost-based time-of-day rates shall be offered on an optional basis to electric consumers who do not otherwise qualify for the rates if consumers agree to pay the additional metering costs and other costs associated with the use of the rates.

20.10(5) Seasonal rates. The rates charged by an electric utility for providing electric service to each class of electric consumers may be on a seasonal basis which reflects the costs of providing service to the class of consumers at different seasons of the year to the extent that costs vary seasonally for the utility, if the board determines that seasonal rates are appropriate in an individual case.

20.10(6) Interruptible rates. Each electric utility shall offer each industrial and commercial electric consumer an interruptible rate which reflects the cost of providing interruptible service to the class of which the consumer is a member.

20.10(7) Load management techniques. Rescinded IAB 11/12/03, effective 12/17/03.

20.10(8) Other energy conservation strategies. Rescinded IAB 11/12/03, effective 12/17/03.

20.10(9) Pilot projects. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.11(476) Customer notification of peaks in electric energy demand.

20.11(1) Pursuant to Iowa Code section 476.17, each investor-owned utility shall have a plan to notify its customers of an approaching peak demand on the day when peak demand is likely to occur. The plan shall be made available to the board upon request.

20.11(2) The plan shall include, at a minimum, the following:

a. A description and explanation of the condition(s) that will prompt a peak alert.

b. A provision for a general notice to be given to customers prior to the time when peak demand is likely to occur and an explanation of when and how notice of an approaching peak in electric demand will be given to customers.

c. The text of the message or messages to be given in the general notice to customers. The message shall include the name of the utility providing the notice, an explanation that conditions exist which indicate a peak in electric demand is approaching, and an explanation of the significance of reductions in electricity use during a period of peak demand and the potential benefits of energy efficiency.

[ARC 1953C, IAB 4/15/15, effective 5/20/15; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.12(476) New structure energy conservation standards. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.13(476) Periodic electric energy supply and cost review [476.6(16)].

20.13(1) Procurement plan. Pursuant to Iowa Code section 476.6(12), the board shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a rate-regulated public utility's practices related to procurement of and contracting for fuel used in generating electricity. When it determines to conduct a contested case proceeding, the board shall notify a rate-regulated utility that it will be required to file an electric fuel procurement plan. The notification to the utility shall include a detailed list of what the board will be examining as part of the review. The utility shall file its plan no later than 105 days after notification unless otherwise directed by the board. A utility's procurement plan shall be organized to include information as follows:

a. Index. The plan shall include an index of all documents and information required to be filed in the plan, and the identification of the board files in which the documents incorporated by reference are located.

b. Purchase contracts and arrangements. A utility's procurement plan shall include detailed summaries of the following types of contracts and agreements executed since the last procurement review:

- (1) All contracts and fuel supply arrangements for obtaining fuel for use by any unit in generation;
- (2) All contracts and arrangements for transporting fuel from point of production to the site where placed in inventory, including any unit generating electricity for the utility;
- (3) All contracts and arrangements for purchasing or selling allowances;
- (4) Purchased power contracts or arrangements, including sale-of-capacity contracts, involving over 25 MW of capacity;
- (5) Pool interchange agreements;
- (6) Multiutility transmission line interchange agreements; and

(7) Interchange agreements between investor-owned utilities, generation and transmission cooperatives, or both, not required to be filed above, which were entered into or in effect since the last filing, and all such contracts or arrangements which will be entered into or exercised by the utility during the prospective 12-month period.

All procurement plans filed by a utility shall include all of the types of contracts and arrangements listed in subparagraphs (1) and (2) of this paragraph which will be entered into or exercised by the utility during the prospective 12-month period. In addition, the utility shall file an updated list of contracts that are or will become subject to renegotiation, extension, or termination within five years. The utility shall also update any price adjustment affecting any of the filed contracts or arrangements.

c. Other contract offers. The procurement plan shall include a list and description of those types of contracts and arrangements listed in paragraph 20.13(1) “b” offered to the utility since the last filing into which the utility did not enter. In addition, the procurement plan shall include a list of those types of contracts and arrangements listed in paragraph 20.13(1) “b” which were offered to the utility for the prospective 12-month period and into which the utility did not enter.

d. Studies or investigation reports. The procurement plans shall include all studies or investigation reports which have been considered by the utility in deciding whether to enter into any of those types of contracts or arrangements listed in paragraphs 20.13(1) “b” and “c” which will be exercised or entered into during the prospective 12-month period.

e. Price hedge justification. The procurement plan shall justify purchasing allowance futures contracts as a hedge against future price changes in the market rather than for speculation.

f. Actual and projected costs. The procurement plan shall include an accounting of the actual costs incurred in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1) “b” for the previous 12-month period.

The procurement plan also shall include an accounting of all costs projected to be incurred by the utility in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1) “b” in the prospective 12-month period.

If applicable, the reporting of transportation costs in the procurement plan shall include all known liabilities, including all unit train costs.

g. Costs directly related to the purchase of fuel. The utility shall provide a list and description of all other costs directly related to the purchase of fuels for use in generating electricity not required to be reported by paragraph “f.”

h. Compliance plans. Each utility shall file its emissions compliance plan as submitted to the EPA. Revisions to the compliance plan shall be filed with each subsequent procurement plan.

i. Evidence submitted. Each utility shall submit all factual evidence and written argument in support of its evaluation of the reasonableness and prudence of the utility’s procurement practice decisions in the manner described in its procurement plan. The utility shall file data sufficient to forecast fuel consumption at each generating unit or power plant for the prospective 12-month period. The board may require the submission of machine-readable data for selected computer codes or models.

j. Additional information. Each utility shall file additional information as ordered by the board.

20.13(2) Periodic review proceeding. Rescinded IAB 12/5/18, effective 1/9/19.
[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.14(476) Flexible rates.

20.14(1) Purpose. This subrule is intended to allow electric utility companies to offer, at their option, incentive or discount rates to their customers.

20.14(2) General criteria.

a. Electric utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customers. However, discounted rates must be offered to all directly competing customers in the same service territory. Customers are direct competitors if they make the

same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

b. In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

c. Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

d. The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

20.14(3) *Tariff requirements.* If a company elects to offer flexible rates, the utility shall file for review and approval tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

a. The cost-benefit analysis must demonstrate that offering the discount will be more beneficial than not offering the discount.

b. The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

c. The floor for the discount rate shall be equal to the energy costs and customer costs of serving the specific customer.

d. No discount shall be offered for a period longer than five years, unless the board determines upon good cause shown that a longer period is warranted.

e. Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

20.14(4) *Reporting requirements.* Each rate-regulated electric utility electing to offer flexible rates shall file annual reports with the board within 30 days of the end of each 12 months. Reports shall include the following information:

a. Section 1 of the report concerns discounts initiated in the last 12 months. For all discounts initiated in the last 12 months, the report shall include:

- (1) The identity of the new customers (by account number, if necessary);
- (2) The value of the discount offered;
- (3) The cost-benefit analysis results;
- (4) The end-use cost of alternate fuels or energy supplies available to the customer, if relevant;
- (5) The energy and demand components by month of the amount of electricity sold to the customer in the preceding 12 months.

b. Section 2 of the report relates to overall program evaluation. Amount of electricity refers to both energy and demand components when the customer is billed for both elements. For all discounts currently being offered, the report shall include:

- (1) The identity of each customer (by account number, if necessary);
- (2) The amount of electricity sold in the last 12 months to each customer at discounted rates, by month;
- (3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month;
- (4) The dollar value of the discount in the last 12 months to each customer, by month; and
- (5) The dollar value of sales to each customer for each of the previous 12 months.

c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:

- (1) Customer identification (by account number, if necessary);
- (2) The amount of electricity sold in the last 12 months to each customer, by month;
- (3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month; and
- (4) The dollar value of sales to each customer for each of the past 12 months.

d. No monthly report is required if the utility had no customers receiving a discount during the relevant period and had no customers which were evaluated for the discount and rejected during the relevant period.

20.14(5) Rate case treatment. In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales were made at full tariffed rates for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.15(476) Customer contribution fund.

20.15(1) Applicability and purpose. This rule applies to each electric public utility, as defined in Iowa Code sections 476.1, 476.1A, and 476.1B. Pursuant to Iowa Code section 476.66, each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

20.15(2) Program plan. Rescinded IAB 12/5/18, effective 1/9/19.

20.15(3) Notification. Each utility shall notify all customers of the customer contribution fund at least twice a year. The method of notice which will ensure the most comprehensive notification to the utility's customers shall be employed. Upon commencement of service and at least once a year, the notice shall be mailed or personally delivered to all customers, or provided by electronic means to those customers who have consented to receiving electronic notices. The other required notice may be published in a local newspaper(s) of general circulation within the utility's service territory. A utility serving fewer than 6,000 customers may publish its semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum, the notice shall include:

a. A description of the availability and the purpose of the fund;

b. A customer authorization form. This form shall include a monthly billing option and any other methods of contribution.

20.15(4) Methods of contribution. The utility shall provide for contributions as monthly pledges, as well as one-time or periodic contributions. A pledge by a customer or other party shall not be construed to be a binding contract between the utility and the pledger. The pledge amount shall not be subject to delayed payment charges by the utility. Each utility may allow persons or organizations to contribute matching funds.

20.15(5) Annual report. On or before September 30 of each year, each utility shall file with the board a report of all the customer contribution fund activity for the previous fiscal year beginning July 1 and ending June 30. The report shall be in a form provided by the board and shall contain an accounting of the total revenues collected and all distributions of the fund. The utility shall report all utility expenses directly related to the customer contribution fund.

20.15(6) Binding effect. Rescinded IAB 12/5/18, effective 1/9/19.

[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.16(476) Exterior flood lighting. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.17(476) Ratemaking treatment of emission allowances.

20.17(1) Applicability and purpose. This rule applies to all rate-regulated utilities providing electric service in Iowa. Under the Clean Air Act, each electric utility is required to hold sufficient emission allowances to offset emissions at all affected and new units. The acquisition and disposition of emission allowances will be treated for ratemaking purposes as defined in this rule.

20.17(2) Definitions. The following words and terms, when used in this rule, shall have the meaning indicated below:

"*Auction allowances*" are allowances acquired or sold through EPA's annual allowance auction.

"*Boot*" means something acquired or forfeited to equalize a trade.

“Direct sale allowances” are allowances purchased from the EPA in its annual direct sale.

“Fair market value” is the amount at which an allowance could reasonably be sold in a transaction between a willing buyer and a willing seller other than in a forced or liquidation sale.

“Historical cost” is the amount of cash or its equivalent paid to acquire an asset, including any direct acquisition expenses. Any commissions paid to brokers shall be considered a direct acquisition expense.

“Original cost” is the historical cost of an asset to the person first devoting the asset to public service.

“Statutory allowances” are allowances allocated by the EPA at no cost to affected units under the Clean Air Act either through annual allocations as a matter of statutory right and those for which a utility may qualify by using certain compliance options or effective use of conservation and renewables.

20.17(3) *Valuing allowances for ratemaking purposes.*

- a. Statutory allowances. Valued at zero cost to electric utility.
- b. Direct sale allowances. Valued at historical cost.
- c. Auction allowances. Valued at historical cost.
- d. Purchased allowances. Valued at historical cost.

20.17(4) *Valuing allowance inventory accounts.* Allowance inventory accounts shall be valued at the weighted average cost of all allowances eligible for use during that year.

20.17(5) *Valuing allowances acquired as part of a package.* Allowances acquired as part of a package with equipment, fuel, or electricity shall be valued at their fair market value at the time the allowances were acquired.

20.17(6) *Valuing allowances acquired through exchanges.*

a. *Exchanges without boot.* Electric utilities shall value allowances received in exchanges based on the recorded inventory value of the allowances relinquished.

b. *Exchanges with boot.* Electric utilities shall value allowances as the sum of the inventory cost of the allowances given up and the monetary consideration paid in boot for the newly acquired allowances. In determining the historical cost of allowances received, a gain (or loss) shall be recorded to the extent that the amount of boot received exceeds a proportionate share of the recorded weighted average inventory cost of the allowance surrendered. The proportionate share shall be based upon the ratio of the monetary consideration received (i.e., boot) to the total consideration received (monetary consideration plus the fair market value of the allowances received). The historical cost of the allowances received shall be equal to the amount derived by subtracting the difference between the boot received and the gain from the old inventory cost.

20.17(7) *Valuing allowances transferred among affiliates.*

a. Allowances transferred from a utility to a parent or unregulated subsidiary. Allowances shall be transferred at the higher of historical cost or fair market value.

b. Allowances transferred from an unregulated subsidiary or parent to a utility. Allowances shall be transferred at the lesser of original cost or fair market value.

c. Allowances transferred from a utility to an affiliated utility. Allowances shall be transferred at fair market value.

20.17(8) *Expense recognition and recovery of allowance costs.*

a. *Expense recognition.* Electric utilities shall charge allowances (including fractional amounts) to expense in the month in which related emissions occur.

b. *Expense recovery.* The expense associated with allowances used for compliance shall be passed through the energy adjustment as specified in rule 199—20.9(476). The expense associated with allowances used for compliance shall include expenses associated with vintage trades and emission for emission trades.

c. *Allowance inventory shortage.* If a utility emits more emissions in a month than it has allowances in inventory, the utility shall pass the estimated cost of acquiring the needed allowances through the energy adjustment. When the needed allowances are acquired, any difference between the

estimated and actual cost of the allowances shall be passed through the energy adjustment as specified in rule 199—20.9(476).

20.17(9) *Gains/losses from allowance transactions.* The gains and losses, including net gains and losses, from allowance transactions shall be passed through the energy adjustment as specified in rule 199—20.9(476). Allowance transactions shall include vintage trades and emission for emission trades.

20.17(10) *Allowance futures or option contracts.*

a. Price hedging. Electric utilities shall defer the costs or benefits from hedging transactions and include such amounts in inventory values when the related allowances are acquired, sold, or otherwise disposed of. Where the costs or benefits of hedging transactions are not identifiable with specific allowances, the amounts shall be included in inventory values when the futures contract is closed.

b. Speculation. Allowance transactions entered into for the purpose of speculation shall not affect allowance inventory pricing.

20.17(11) *Working capital reserve of allowances.* A working capital reserve of allowances shall be established in each utility's rate case proceeding based on the probability of forced outages, fuel quality variability, variability in load growth, nuclear exposure, the price and availability of allowances on the national market, and any other factors that the board deems appropriate. The working capital reserve will earn at the utility's authorized rate of return.

20.17(12) *Allowances banked for future use.* Allowances banked for future use shall be considered plant held for future use in utility rate proceedings if a definitive plan and schedule for use of the allowances is deemed adequate by the board.

20.17(13) *Prudence of allowance transactions.* The prudence of allowance transactions shall be determined by the board in the periodic electric energy supply and cost review. The prudency review of allowance transactions and accompanying compliance plans shall be based on information available at the time the options or plans were developed. Costs recovered from ratepayers through the energy adjustment that are deemed imprudent by the board shall be refunded with interest to ratepayers through the energy adjustment as specified in rule 199—20.9(476).

[ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.18(476,478) Service reliability requirements for electric utilities.

20.18(1) *Applicability.* This rule is applicable to investor-owned electric utilities and electric cooperative corporations and associations operating within the state of Iowa subject to Iowa Code chapter 476 and to the construction, operation, and maintenance of electric transmission lines by electric utilities as defined in subrule 20.18(4) to the extent provided in Iowa Code chapter 478.

20.18(2) *Purpose and scope.* Reliable electric service is of high importance to the health, safety, and welfare of the citizens of Iowa. The purpose of this rule is to establish requirements for assessing the reliability of the transmission and distribution systems and facilities that are under the board's jurisdiction. This rule establishes reporting requirements to provide consumers, the board, and electric utilities with methodology for monitoring reliability and ensuring quality of electric service within an electric utility's operating area. This rule provides definitions and requirements for maintenance of interruption data, retention of records, and report filing.

20.18(3) *General obligations.*

a. Each electric utility shall make reasonable efforts to avoid and prevent interruptions of service. However, when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety.

b. The electric utility's electrical transmission and distribution facilities shall be designed, constructed, maintained, and electrically reinforced and supplemented as required to reliably perform the power delivery burden placed upon them in the storm and traffic hazard environment in which they are located.

c. Each electric utility shall carry on an effective preventive maintenance program and shall be capable of emergency repair work on a scale which its storm and traffic damage record indicates as appropriate to its scope of operations and to the physical condition of its transmission and distribution facilities.

d. In appraising the reliability of the electric utility's transmission and distribution system, the board will consider the condition of the physical property and the size, training, supervision, availability, equipment, and mobility of the maintenance forces, all as demonstrated in actual cases of storm and traffic damage to the facilities.

e. Each electric utility shall keep records of interruptions of service on its primary distribution system and shall make an analysis of the records for the purpose of determining steps to be taken to prevent recurrence of such interruptions.

f. Each electric utility shall make reasonable efforts to reduce the risk of future interruptions by taking into account the age, condition, design, and performance of transmission and distribution facilities and providing adequate investment in the maintenance, repair, replacement, and upgrade of facilities and equipment.

g. Any electric utility unable to comply with applicable provisions of this rule may file a waiver request pursuant to rule 199—1.3(17A,474,476).

20.18(4) Definitions. Terms and formulas when used in this rule are defined as follows:

"Customer" means (1) any person, firm, association, or corporation, (2) any agency of the federal, state, or local government, or (3) any legal entity responsible by law for payment of the electric service from the electric utility which has a separately metered electrical service point for which a bill is provided. Electrical service point means the point of connection between the electric utility's equipment and the customer's equipment. Each meter equals one customer. Retail customers are end-use customers who purchase and ultimately consume electricity.

"Customer average interruption duration index (CAIDI)" means the average interruption duration for those customers who experience interruptions during the year. It is calculated by dividing the annual sum of all customer interruption durations by the total number of customer interruptions.

$$\text{CAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customer Interruptions}}$$

"Distribution system" means that part of the electric system owned or operated by an electric utility and designed to operate at a nominal voltage of 25,000 volts or less.

"Electric utility" means investor-owned electric utilities and electric cooperative corporations and associations owning, controlling, operating, or using transmission and distribution facilities and equipment subject to the board's jurisdiction.

"GIS" means a geospatial information system. This is an information management framework that allows the integration of various data and geospatial information.

"Interrupting device" means a device capable of being reclosed whose purpose is to interrupt faults and restore service or disconnect loads. These devices can be manual, automatic, or motor-operated. Examples may include transmission breakers, feeder breakers, line reclosers, motor-operated switches, fuses, or other devices.

"Interruption" means a loss of service to one or more customers or other facilities and is the result of one or more component outages. The types of interruption include momentary event, sustained, and scheduled. The following interruption causes shall not be included in the calculation of the reliability indices:

1. Interruptions intentionally initiated pursuant to the provisions of an interruptible service tariff or contract and affecting only those customers taking electric service under such tariff or contract;
2. Interruptions due to nonpayment of a bill;
3. Interruptions due to tampering with service equipment;
4. Interruptions due to denied access to service equipment located on the affected customer's private property;
5. Interruptions due to hazardous conditions located on the affected customer's private property;
6. Interruptions due to a request by the affected customer;

7. Interruptions due to a request by a law enforcement agency, fire department, other governmental agency responsible for public welfare, or any agency or authority responsible for bulk power system security;

8. Interruptions caused by the failure of a customer's equipment; the operation of a customer's equipment in a manner inconsistent with law, an approved tariff, rule, regulation, or an agreement between the customer and the electric utility; or the failure of a customer to take a required action that would have avoided the interruption, such as failing to notify the company of an increase in load when required to do so by a tariff or contract.

"Interruption duration" as used herein in regard to sustained outages means a period of time measured in one-minute increments that starts when an electric utility is notified or becomes aware of an interruption and ends when an electric utility restores electric service. Durations of less than five minutes shall not be reported in sustained outages.

"Interruption, momentary" means single operation of an interrupting device that results in a voltage of zero. For example, two breaker or recloser operations equals two momentary interruptions. A momentary interruption is one in which power is restored automatically.

"Interruption, momentary event" means an interruption of electric service to one or more customers of duration limited to the period required to restore service by an interrupting device. Note: Such switching operations must be completed in a specified time not to exceed five minutes. This definition includes all reclosing operations that occur within five minutes of the first interruption. For example, if a recloser or breaker operates two, three, or four times and then holds, the event shall be considered one momentary event interruption.

"Interruption, scheduled" means an interruption of electric power that results when a transmission or distribution component is deliberately taken out of service at a selected time, usually for the purposes of construction, preventive maintenance, or repair. If it is possible to defer the interruption, the interruption is considered a scheduled interruption.

"Interruption, sustained" means any interruption not classified as a momentary event interruption. It is an interruption of electric service that is not automatically or instantaneously restored, with duration of greater than five minutes.

"Loss of service" means the loss of electrical power, a complete loss of voltage, to one or more customers. This does not include any of the power quality issues such as sags, swells, impulses, or harmonics. Also see definition of "interruption."

"Major event" will be declared whenever extensive physical damage to transmission and distribution facilities has occurred within an electric utility's operating area due to unusually severe and abnormal weather or event and:

1. Wind speed exceeds 90 mph for the affected area, or
2. One-half inch of ice is present and wind speed exceeds 40 mph for the affected area, or
3. Ten percent of the affected area total customer count is incurring a loss of service for a length of time to exceed five hours, or
4. 20,000 customers in a metropolitan area are incurring a loss of service for a length of time to exceed five hours.

"Meter" means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

"Metropolitan area" means any community, or group of contiguous communities, with a population of 20,000 individuals or more.

"Momentary average interruption frequency index (MAIFI)" means the average number of momentary electric service interruptions for each customer during the year. It is calculated by dividing the total number of customer momentary interruptions by the total number of customers served.

$$\text{MAIFI} = \frac{\text{Total Number of Customer Momentary Interruptions}}{\text{Total Number of Customers Served}}$$

“OMS” is a computerized outage management system.

“Operating area” means a geographical area defined by the electric utility that is a distinct area for administration, operation, or data collection with respect to the facilities serving, or the service provided within, the geographical area.

“Outage” means the state of a component when it is not available to perform its intended function due to some event directly associated with that component. An outage may or may not cause an interruption of service to customers, depending on system configuration.

“Power quality” means the characteristics of electric power received by the customer, with the exception of sustained interruptions and momentary event interruptions. Characteristics of electric power that detract from its quality include waveform irregularities and voltage variations, either prolonged or transient. Power quality problems shall include, but are not limited to, disturbances such as high or low voltage, voltage spikes and transients, flickers and voltage sags, surges and short-time overvoltages, as well as harmonics and noise.

“Rural circuit” means a circuit not defined as an urban circuit.

“System average interruption duration index (SAIDI)” means the average interruption duration per customer served during the year. It is calculated by dividing the sum of the customer interruption durations by the total number of customers served during the year.

$$\text{SAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customers Served}}$$

“System average interruption frequency index (SAIFI)” means the average number of interruptions per customer during the year. It is calculated by dividing the total annual number of customer interruptions by the total number of customers served during the year.

$$\text{SAIFI} = \frac{\text{Total Number of Customer Interruptions}}{\text{Total Number of Customers Served}}$$

“Total number of customers served” means the total number of customers served on the last day of the reporting period.

“Urban circuit” means a circuit where both 75 percent or more of its customers and 75 percent or more of its primary circuit miles are located within a metropolitan area.

20.18(5) Record-keeping requirements.

a. Required records for electric utilities with over 50,000 Iowa retail customers.

(1) Each electric utility shall maintain a geospatial information system (GIS) and an outage management system (OMS) sufficient to determine a history of sustained electric service interruptions experienced by each customer. The OMS shall have the ability to access data for each customer in order to determine a history of electric service interruptions. Data shall be sortable by each of, and in any combination with, the following factors:

1. State jurisdiction;
 2. Operating area (if any);
 3. Substation;
 4. Circuit;
 5. Number of interruptions in reporting period; and
 6. Number of hours of interruptions in reporting period.
- (2) Records on interruptions shall be sufficient to determine the following:
1. Starting date and time the utility became aware of the interruption;
 2. Duration of the interruption;
 3. Date and time service was restored;
 4. Number of customers affected;
 5. Description of the cause of the interruption;
 6. Operating areas affected;

7. Circuit number(s) of the distribution circuit(s) affected;
 8. Service account number or other unique identifier of each customer affected;
 9. Address of each affected customer location;
 10. Weather conditions at time of interruption;
 11. System component(s) involved (e.g., transmission line, substation, overhead primary main, underground primary main, transformer); and
 12. Whether the interruption was planned or unplanned.
- (3) Each electric utility shall maintain as much information as feasible on momentary interruptions.
- (4) Each electric utility shall keep information on cause codes, weather codes, isolating device codes, and equipment failed codes.

1. The minimum interruption cause code set should include: animals, lightning, major event, scheduled, trees, overload, error, supply, equipment, other, unknown, and earthquake.

2. The minimum interruption weather code set should include: wind, lightning, heat, ice/snow, rain, clear day, and tornado/hurricane.

3. The minimum interruption isolating device set should include: breaker, recloser, fuse, sectionalizer, switch, and elbow.

4. The minimum interruption equipment failed code set should include: cable, transformer, conductor, splice, lightning arrester, switches, cross arm, pole, insulator, connector, other, and unknown.

5. Utilities may augment the code sets listed above to enhance tracking.

(5) An electric utility shall retain for seven years the records required by 20.18(5) "a"(1) through (4).

(6) Each electric utility shall record the date of installation of major facilities (poles, conductors, cable, and transformers) installed on or after April 1, 2003, and integrate that data into its GIS database.

b. Required records for all other electric utilities.

(1) Each electric utility, other than those providing only wholesale electric service, shall record and maintain sufficient records and reports that will enable it to calculate for the most recent seven-year period the average annual hours of interruption per customer due to causes in each of the following four major categories: power supplier, major storm, scheduled, and all other. Those electric utilities that provide only wholesale electric service shall provide their wholesale customers with the information necessary to allow those customers to ascertain the cause of power supply-related outages.

The category "scheduled" refers to interruptions resulting when a distribution transformer, line, or owned substation is deliberately taken out of service at a selected time for maintenance or other reasons.

The interruptions resulting from either scheduled or unscheduled outages on lines or substations owned by the power supplier are to be accounted for in the "power supplier" category.

The category "major storm" represents service interruptions from conditions that cause many concurrent outages because of snow, ice, or wind loads that exceed design assumptions for the lines.

The "all other" category includes outages primarily resulting from emergency conditions due to equipment breakdown, malfunction, or human error.

(2) When recording interruptions, each electric utility, other than those providing only wholesale electric service, shall use detailed standard codes for interruption analysis recommended by the United States Department of Agriculture, Rural Utilities Service (RUS) Bulletin 1730A-119, Tables 1 and 2, including the major cause categories of equipment or installation, age or deterioration, weather, birds or animals, member (or public), and unknown. The utility shall also include the subcategories recommended by RUS for each of these major cause categories.

(3) Each electric utility, other than those providing only wholesale electric service, shall also maintain and record data sufficient to enable it to compute systemwide calculated indices for SAIFI-, SAIDI-, and CAIDI-type measurements, once with the data associated with "major storms" and once without.

c. Each electric utility shall make its records of customer interruptions available to the board as needed.

20.18(6) Notification of major events. Notification of major events as defined in subrule 20.18(4) shall comply with the requirements of rule 199—20.19(476,478).

20.18(7) *Annual reliability and service quality report for utilities with more than 50,000 Iowa retail customers.* Each electric utility with over 50,000 Iowa retail customers shall submit to the board on or before May 1 of each year an annual reliability report for the previous calendar year for the Iowa jurisdiction. The report shall include the following information:

a. Description of service area. Urban and rural Iowa service territory customer count, Iowa operating area customer count, if applicable, and major communities served within each operating area.

b. System reliability performance.

(1) An overall assessment of the reliability performance, including the urban and rural SAIFI, SAIDI, and CAIDI reliability indices for the previous calendar year for the Iowa service territory and each defined Iowa operating area, if applicable. This assessment shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. These indices shall be calculated twice, once with the data associated with major events and once without. This assessment should contain tabular and graphical presentations of the trend for each index as well as the trends of the major causes of interruptions.

(2) The urban and rural SAIFI, SAIDI, and CAIDI reliability average indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area, if applicable. The reliability average indices shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. Calculation of the five-year average shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal a complete five-year average shall be available. These indices shall be calculated twice, once with the data associated with major events and once without.

(3) The MAIFI reliability indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area for which momentary interruptions are tracked. The first annual report should specify which portions of the system are monitored for momentary interruptions, identify and describe the quality of data used, and update as needed in subsequent reports.

c. Reporting on customer outages.

(1) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced set numbers of sustained interruptions during the year (i.e., the number of customers who experienced zero interruptions, the number of customers who experienced one interruption, two interruptions, three interruptions, and so on). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.
2. All Iowa customers, including major events.

(2) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced a set range of total annual sustained interruption duration during the year (i.e., the number of customers who experienced zero hours total duration, the number of customers who experienced greater than 0.0833 but less than 0.5 hour total duration, the number of customers who experienced greater than 0.5 but less than 1.0 hour total duration, and so on, reflecting half-hour increments of duration). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.
2. All Iowa customers, including major events.

d. Major event summary. For each major event that occurred in the reporting period, the following information shall be provided:

- (1) A description of the area(s) impacted by each major event;
- (2) The total number of customers interrupted by each major event;
- (3) The total number of customer-minutes interrupted by each major event; and
- (4) Updated damage cost estimates to the electric utility's facilities.

e. Information on transmission and distribution facilities.

(1) Total circuit miles of electric distribution line in service at year's end, segregated by voltage level. Reasonable groupings of lines with similar voltage levels, such as but not limited to 12,000- and 13,000-volt three-phase facilities, are acceptable.

(2) Total circuit miles of electric transmission line in service at year's end, segregated by voltage level.

f. Plans and status report. A plan for service quality improvements, including costs, for the electric utility's transmission and distribution facilities that will ensure quality, safe, and reliable delivery of energy to customers.

g. Capital expenditure information. Reporting of capital expenditure information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Each electric utility shall report on an annual basis the total of:

1. Capital investment in the electric utility's Iowa-based transmission and distribution infrastructure approved by its board of directors or other appropriate authority. If any amounts approved by the board of directors are designated for use in a recovery from a major event, those amounts shall be identified in addition to the total.

2. Capital investment expenditures in the electric utility's Iowa-based transmission and distribution infrastructure. If any expenditures were utilized in a recovery from a major event, those amounts shall be identified in addition to the total.

(2) Each electric utility shall report the same capital expenditure data from the past five years in the same fashion as in 20.18(7) "g"(1).

h. Maintenance. Reporting of maintenance information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Total maintenance budgets and expenditures for distribution, and for transmission, for each operating area, if applicable, and for the electric utility's entire Iowa system for the past five years. If any maintenance budgets and expenditures are designated for use in a recovery from a major event, or were used in a recovery from a major event, respectively, those amounts shall be identified in addition to the totals.

(2) Tree trimming.

1. The budget and expenditures described in 20.18(7) "h"(1) shall be stated in such a way that the total annual tree trimming budget expenditures shall be identifiable for each operating area and for the electric utility's entire Iowa system for the past five years.

2. Total annual projected and actual miles of transmission line and of distribution line for which trees were trimmed for the reporting year for each operating area and for the electric utility's entire Iowa system for the reporting year, compared to the past five years. If the utility has utilized, or would prefer to utilize, an alternative method or methods of tracking physical tree trimming progress, it may propose the use of that method or methods to the board in a request for waiver.

3. In the event the utility's actual tree trimming performance, based on how the utility tracks its tree trimming as described in 20.18(7) "h"(2) "1," lags behind its planned trimming schedule by more than six months, the utility shall be required to file for the board's approval additional tree trimming status reports on a quarterly basis. Such reports shall describe the steps the utility will take to remediate its tree trimming performance and backlog. The additional quarterly reports shall continue until the utility's backlog has been reduced to zero.

i. The annual reliability report shall include the number of poles inspected, the number rejected, and the number replaced.

20.18(8) Annual report for all electric utilities not reporting pursuant to 20.18(7).

a. Each electric utility shall adopt and have approved by its board of directors or other governing authority a reliability plan. The plan shall be updated not less than annually.

b. By April 1 of each year, each electric utility shall prepare for its board of directors or other governing authority a reliability report. A copy of the annual report shall be filed with the board for

informational purposes, shall be made publicly available in its entirety to customers/consumer owners, and shall report on the reliability indices in 20.18(5) “b”(3) for each of the five previous calendar years.

20.18(9) *Inquiries about electric service reliability.*

a. For electric utilities with over 50,000 Iowa retail customers. A customer may request a report from an electric utility about the service reliability of the circuit supplying the customer’s own meter. Within 20 working days of receipt of the request, the electric utility shall supply the report to the customer at a reasonable cost. The report should identify which interruptions (number and durations) are due to major events.

b. Other utilities are encouraged to adopt similar responses to the extent it is administratively feasible.

[ARC 8394B, IAB 12/16/09, effective 1/20/10; ARC 9501B, IAB 5/18/11, effective 6/22/11; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.19(476,478) Notification of outages.

20.19(1) *Notification.* The notification requirements in subrules 20.19(1) and 20.19(2) are for the timely collection of electric outage information that may be useful to emergency management agencies in providing for the welfare of individual Iowa citizens. Each electric utility shall notify the board when it is projected that an outage may result in a loss of service for more than six hours and the outage meets one of the following criteria:

a. For all utilities, loss of service for more than six hours to substantially all of a municipality, including the surrounding area served by the same utility. A utility may use loss of service to 75 percent or more of customers within a municipality, including the surrounding area served by the utility, to meet this criterion;

b. For utilities with 50,000 or more customers, loss of service for more than six hours to 20 percent of the customers in a utility’s established zone or loss of service to more than 5,000 customers in a metropolitan area, whichever is less;

c. For utilities with more than 4,000 customers and fewer than 50,000 customers, loss of service for more than six hours to 25 percent or more of the utility’s customers;

d. A major event as defined in subrule 20.18(4); or

e. Any other outage considered significant by the electric utility. This includes loss of service for more than six hours to significant public health and safety facilities known to the utility at the time of the notification, even when the outage does not meet the criteria in paragraphs 20.19(1) “a” through “d.”

20.19(2) *Information required.*

a. Notification shall be provided regarding outages that meet the requirements of subrule 20.19(1) by notifying the board duty officer by email at dutyofficer@iub.iowa.gov or, in appropriate circumstances, by telephone at (515)745-2332. Notification shall be made at the earliest possible time after it is determined the event may be reportable and should include the following information, as available:

- (1) The general nature or cause of the outage;
- (2) The area affected;
- (3) The approximate number of customers that have experienced a loss of electric service as a result of the outage;
- (4) The time when service is estimated to be restored; and
- (5) The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the outage.

The notice should be supplemented as more complete or accurate information is available.

b. The utility shall provide to the board updates of the estimated time when service will be restored to all customers able to receive service or of significant changed circumstances, unless service is restored within one hour of the time initially estimated.

c. The utility shall notify the board once service is fully restored to all customers after an outage meeting the requirements of subrule 20.19(1).

[ARC 8394B, IAB 12/16/09, effective 1/20/10; Editorial change: IAC Supplement 12/29/10; ARC 9819B, IAB 11/2/11, effective 12/7/11; ARC 1359C, IAB 3/5/14, effective 4/9/14; ARC 1623C, IAB 9/17/14, effective 10/22/14; ARC 4171C, IAB 12/5/18, effective 1/9/19]

199—20.20(476) Electric vehicle charging service.

20.20(1) A commercial or public electric vehicle charging station is not a public utility under Iowa Code section 476.1 if the charging station receives all electric power from the electric utility in whose service area the charging station is located. If an electric vehicle charging station obtains electric power from a source other than the electric utility, the determination of whether the commercial or public electric vehicle charging station is a public utility shall be resolved by the board.

20.20(2) A person, partnership, business association, or corporation, foreign or domestic, furnishing electricity to a commercial or public electric vehicle charging station shall comply with Iowa Code section 476.25 and, if applicable, with the terms and conditions of the public utility's tariffs or service rules.

20.20(3) A rate-regulated public utility shall not, through its filed tariff, prohibit electric vehicle charging or restrict the method of sale of electric vehicle charging at a commercial or public electric vehicle charging station.

20.20(4) Electric utilities and entities providing commercial or public electric vehicle charging service shall comply with all applicable statutes and regulations governing the provision of electric vehicle charging service, including but not limited to all taxing requirements, and shall, if necessary, file all appropriate tariffs.

[ARC 5608C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code sections 17A.3, 364.23, 474.5, 476.1, 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 478.18, and 546.7.

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³ See IAB, Utilities Division.

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⁵ Effective date of 20.4(4) delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

“Bona fide residence” or *“bona fide address,”* as set forth in Iowa Code section 321.1(6C), means the pre-disaster street or highway address of an individual’s dwelling or dwelling unit. The bona fide residence of a homeless person is a primary nighttime residence meeting one of the criteria listed in Iowa Code section 48A.2(2).

“Department” means the Iowa department of human services.

“Dwelling” or *“dwelling unit”* means the structure in which a household resides. *“Dwelling”* or *“dwelling unit”* includes permanent structures, mobile homes, manufactured homes, modular homes, fifth-wheel travel trailers, travel trailers, and motor homes in which a household resides.

“Emergency management coordinator” means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

“Fifth-wheel travel trailer,” as set forth in Iowa Code section 321.1(36C) *“c,”* means a type of travel trailer which is towed by a pickup by a connecting device known as a fifth wheel. However, this type of travel trailer may have an overall length which shall not exceed 45 feet. If the vehicle is used in this state as a place of human habitation for more than 180 consecutive days in one location, the vehicle shall be classed as a manufactured or mobile home regardless of the size limitations provided in this definition.

“Home” means the pre-disaster dwelling or dwelling unit for a household.

“Household” means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

“Manufactured home” or *“modular home,”* as set forth in Iowa Code section 321.1(36B), is a factory-built structure constructed under authority of 42 U.S.C. §5403, which is required by federal law to display a seal from the United States Department of Housing and Urban Development, and was constructed on or after June 15, 1976.

“Manufactured or mobile home,” as set forth in Iowa Code section 321.1(36C) *“a,”* means any vehicle without motive power used or so manufactured or constructed as to permit its being used as a conveyance upon the public streets and highways and so designed, constructed, or reconstructed as will permit the vehicle to be used as a place for human habitation by one or more persons.

“Motor home,” as set forth in Iowa Code section 321.1(36C) *“d,”* means a motor vehicle designed as an integral unit to be used as a conveyance upon the public streets and highways and for use as a temporary or recreational dwelling and having at least four, two of which shall be systems specified in paragraph *“1,” “4,”* or *“5”* of this definition, of the following permanently installed systems which meet American National Standards Institute and National Fire Protection Association standards in effect on the date of manufacture:

1. Cooking facilities.
2. Ice box or mechanical refrigerator.
3. Potable water supply including plumbing and a sink with faucet either self-contained or with connections for an external source, or both.

4. Self-contained toilet or a toilet connected to a plumbing system with connection for external water disposal, or both.

5. Heating or air conditioning system or both, separate from the vehicle engine or the vehicle engine electrical system.

6. A 110- to 115-volt alternating current electrical system separate from the vehicle engine electrical system either with its own power supply or with a connection for an external source, or both, or a liquefied petroleum system and supply. If the vehicle is used in this state as a place of human habitation for more than 90 consecutive days in one location, the vehicle shall be classed as a manufactured or mobile home regardless of the size limitations provided in this definition.

“*Necessary expense*” means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

“*Owner*” means one or more persons, jointly or severally, in whom is vested all or part of the legal title to property or all or part of the beneficial ownership and a right to present use and enjoyment of the property. “*Owner*” includes a mortgagee in possession.

“*Rent*” means an amount paid to the landlord under the rental agreement.

“*Safe, sanitary, and secure*” means free from disaster-related health hazards.

“*Serious need*” means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

“*Tenant*” means a person or persons entitled under a rental agreement to occupy a dwelling or dwelling unit to the exclusion of others.

“*Travel trailer,*” as set forth in Iowa Code section 321.1(36C) “*b,*” means a vehicle without motive power used, manufactured, or constructed to permit its use as a conveyance upon the public streets and highways and designed to permit its use as a place of human habitation by one or more persons. The vehicle may be up to 8 feet, 6 inches in width and its overall length shall not exceed 45 feet. The vehicle shall be customarily or ordinarily used for vacation or recreational purposes and not used as a place of permanent habitation. If the vehicle is used in this state as a place of human habitation for more than 180 consecutive days in one location, the vehicle shall be classed as a manufactured or mobile home regardless of the size limitations provided in this definition.

[ARC 1353C, IAB 3/5/14, effective 5/1/14; ARC 3058C, IAB 5/10/17, effective 7/1/17; ARC 5596C, IAB 5/5/21, effective 7/1/21]

441—58.2(29C) Program implementation.

58.2(1) Disaster declaration. The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a declaration of a state of disaster emergency that authorizes individual assistance. The program shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

58.2(2) Voucher system. The IIAGP will be implemented through a reimbursement or voucher system.

58.2(3) Program extensions.

a. The program may be extended beyond 120 days through an extension of the governor’s disaster proclamation; or

b. The program may be extended in 30-day intervals requested by the applicant household through the contracted entity and approved by the department.

[ARC 9128B, IAB 10/6/10, effective 10/1/10; ARC 9312B, IAB 12/29/10, effective 3/1/11; ARC 1353C, IAB 3/5/14, effective 5/1/14; ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.3(29C) Application for assistance. To request assistance for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the contracted administrative entity along with: (1) receipts for the claimed expenses or (2) a request to participate in a voucher system.

58.3(1) Application forms are available from an approved administrative entity, as well as the Internet website of the department at www.dhs.iowa.gov.

58.3(2) The application shall include:

a. A declaration of the household’s annual income, accompanied by:

- (1) A current pay stub, W-2 form, or income tax return, or
- (2) Documentation of current enrollment in an assistance program administered by the department, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or other subsidy program.
 - b.* An authorization to release confidential information to personnel involved in administering the program.
 - c.* A certification of the accuracy of the information provided.
 - d.* An assurance that the household had no insurance coverage for claimed items.
 - e.* A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.
 - f.* A short, handwritten narrative of how the disaster event caused the claimed loss.
 - g.* A copy of a picture identification document for each adult applicant.
 - h.* When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

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441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's bona fide residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income. Proof of income is required.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance or that are less than the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

58.4(6) Household eligibility for home repair assistance for a dwelling or dwelling unit damaged due to a proclaimed disaster is only available for a household that owns and occupies the dwelling or dwelling unit being repaired.

[ARC 1353C, IAB 3/5/14, effective 5/1/14; ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is \$5,000. Assistance is available under the program for the following disaster-related expenses:

58.5(1) Personal property and food assistance may be issued for damage to personal property or loss of food, including the following items, based on the item's condition:

a. Kitchen items, excluding large appliances up to a maximum of \$560, including:

- (1) Small appliances, e.g., toaster, blender, microwave, and
- (2) Furnishings (e.g., tables, chairs).

b. Large kitchen appliances or laundry appliances, up to a maximum of \$700 per appliance and a maximum per household not to exceed \$2,800, if the appliances are owned by the household and not a landlord.

c. Food, up to a maximum of \$50 for one person plus \$25 for each additional person in the household.

d. Personal hygiene items, up to a maximum of \$30 per person and \$150 per household.

- e.* Bedroom furnishings, up to \$500 per person.
- f.* Clothing, up to a maximum of \$145 per person.
- g.* Living area furnishings, such as: couch, chair, end tables, and television, up to a maximum of \$1,000.
- h.* Other items, including:
 - (1) Dehumidifier, up to a maximum of \$250.
 - (2) One window air conditioner, up to a maximum of \$250.
- i.* Vehicle repair, up to a maximum of \$500.

58.5(2) Home repair assistance may be issued for home repair for an owner-occupied dwelling or dwelling unit as needed to make the dwelling or dwelling unit safe, sanitary, and secure, up to a maximum of \$5,000.

- a.* Assistance will be denied if preexisting conditions are the cause of the damage.
- b.* Assistance may be authorized for:
 - (1) The repair of structural components, such as the foundation and roof.
 - (2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.
 - (3) Debris removal, including trees, up to a maximum of \$1,000.
- c.* Repairs to rental dwellings or dwelling units or landlord-owned equipment are excluded under this program.
- d.* Bathroom, up to a maximum of \$1,500, including toilet, sink, and tub/shower.
- e.* Sump pump (in a flood event only), up to a maximum of \$200 installed.
- f.* Electrical or mechanical repairs, up to a maximum of \$2,000.
- g.* Water heater, up to a maximum of \$1,500 installed.
- h.* Heating systems, up to a maximum of \$2,100 installed.
- i.* Air-conditioning systems, up to a maximum of \$2,100 installed.
- j.* Water well repair for dwellings or dwelling units with no other source of water available, up to a maximum of \$2,000.
- k.* Water softener repair, up to a maximum of \$500.

58.5(3) Temporary housing assistance may be issued to a household, up to a limit of \$65 per day, for lodging at a licensed establishment, such as a hotel or motel. The household's home must be considered to be destroyed, uninhabitable, inaccessible, or unavailable to the household. Temporary housing assistance may also be granted for deposits for a new dwelling. Total temporary housing assistance may not exceed \$2,500.

58.5(4) Replacement, repair, or provision of other items of necessity may be approved by the department on a case-by-case basis, up to a maximum of \$5,000.

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441—58.6(29C) Eligibility determination and payment.

58.6(1) The contracted entity or designee shall confirm that the bona fide address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area. The department or contracted entity reserves the right to view the damaged property prior to providing any assistance pursuant to IIAGP.

58.6(2) Designated staff in the department shall:

- a.* Monitor applicants' names and addresses as reports are submitted by the administrative entity.
- b.* Monitor, review, and provide timely submission of invoices by the administrative entity for payment and shall process appeals.

58.6(3) For applications with a voucher or reimbursement request, the department or its designee shall:

- a.* Determine eligibility and the amount of payment within the rules of the program.
- b.* Notify the applicant household of the eligibility decision.
- c.* Authorize vouchers to an eligible household to purchase needed goods and services.

d. Pay vendors for goods and services purchased with vouchers.
[ARC 9128B, IAB 10/6/10, effective 10/1/10; ARC 9312B, IAB 12/29/10, effective 3/1/11; ARC 1353C, IAB 3/5/14, effective 5/1/14; ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.7(29C) Contested cases.

58.7(1) Reconsideration.

a. The household may request reconsideration of decisions regarding eligibility and the amount of assistance awarded.

b. To request reconsideration, the household shall submit a written request to the DHS Division of Field Operations—Emergency Assistance, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the letter notifying the household of the department’s decision.

c. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) Appeal. The household may appeal the department’s reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.
[ARC 9312B, IAB 12/29/10, effective 3/1/11; ARC 1353C, IAB 3/5/14, effective 5/1/14; ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.8(29C) Discontinuance of program.

58.8(1) Deferral to federal assistance. Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the Iowa individual assistance grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) Exhaustion of funds. The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. “First-come, first-served” is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds shall be reserved for final appeal decisions reversing the department’s denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued shall be denied. These rules are intended to implement Iowa Code chapter 29C.

441—58.9 to 58.20 Reserved.

DIVISION II IOWA DISASTER CASE MANAGEMENT

441—58.21(29C) Purpose. The purpose of these rules is to guide the provision of the Iowa disaster case management (IDCM) program during the time of emergency disaster for individual assistance when a disaster is proclaimed by the governor of the state of Iowa.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.22(29C) Definitions.

“*Contracted entity*” means an entity chosen by the department as the contracted administrator for the IDCM program.

“*Emergency management coordinator*” means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

“*Household*” means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

“*Necessary services*” means the guidance and advice in obtaining a service, or assistance in obtaining resources from various providers for any other activity that addresses a serious need.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.23(29C) Program implementation.

58.23(1) *Disaster proclamation.* The Iowa disaster case management (IDCM) program shall be implemented when the governor issues a proclamation of a state of emergency disaster that authorizes individual assistance.

a. The program shall be in effect only in those counties named in the proclamation. Assistance for a state-only proclamation shall be provided for a period of up to 180 days from the date of proclamation.

b. A request for an additional 90-day extension to the period of performance will be considered when adequate justification is presented to the department.

c. The program shall commence on the day following proclamation of a disaster by the governor and remain in effect through 180 days even if the disaster becomes a presidentially proclaimed disaster that authorizes individual assistance.

d. The period of performance for presidentially proclaimed disaster is 24 months from the date of the presidential proclamation.

e. The reporting of the numbers of contacts, cases opened, cases pending, cases closed, and other required reports requested by the department shall be submitted weekly on a day determined by the department.

f. Audits of disaster case files, as well as cost management and expenditures, may be randomly performed by the department without notice.

58.23(2) *Contracting.* The administrative entity currently under contract for the Iowa disaster aid individual assistance grant program (IIAGP) shall receive an amended contract to specify administration of the IDCM program.

a. Future contract renewals shall be inclusive with the IIAGP and as amended to include the IDCM program.

b. If a local contracted entity is under contract with the state to provide other services or is implementing a state or federal program and the contract contains a sufficient surety bond or other adequate financial responsibility provision, the department shall accept the existing surety bond or financial responsibility provisions in lieu of applying a new or additional surety bond or financial responsibility requirement.

c. The contracted entity shall coordinate activities with emergency management coordinators and voluntary organizations active in the disaster while the program is active. The contracted entity may subcontract with other entities to provide disaster case management with the approval of the department.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.24(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.24(1) The household’s residence was located in the area identified in the disaster proclamation during the designated incident period and the household verifies occupancy at that residence.

58.24(2) Household members are citizens of the United States or are legally residing in the United States.

58.24(3) The household has disaster-related needs that represent a burden that the family is unable to resolve.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.25(29C) Services. Disaster case management is a time-limited resource and process that involves a partnership between a case manager and a household impacted by a disaster (also known as a client) to develop and carry out a disaster recovery plan. This partnership provides the client with a single point of contact to facilitate access to a broad range of resources, promoting sustainable assistance for individuals and a household's recovery. These services are client-focused and provided in a manner consistent with standards for trauma-informed practice in human services.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.26(29C) Disaster-caused unmet needs. A disaster-caused unmet need is an unresourced item, support, or assistance that has been assessed by a representative from a local, state, tribal, federal agency, voluntary, or faith-based organization and that is needed for the client to recover from the disaster. Unmet disaster-caused needs may also include basic and immediate needs, such as food, clothing, shelter, or first aid, and long-term needs, such as financial, physical, emotional or spiritual well-being.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.27(29C) Resources. Applicable resources may include, but not be limited to, insurance payments, state assistance, voluntary/faith-based and local community assistance, federal disaster assistance, small business administration loans, and personal resources.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.28(29C) Standards and policies.

58.28(1) Access. The contracted entity shall provide clients with ease of access to disaster case management services.

58.28(2) Confidentiality and duplications of benefits.

a. The contracted entity shall have policies and procedures to meet requirements regarding maintaining confidentiality set forth by the department.

b. The contracted entity shall develop memorandums of agreement, memorandums of understanding, and release of information that will allow coordinated case advocacy and services and prevent the duplication of benefits.

58.28(3) Engagement. The case manager shall create a sustainable, trusting partnership with the client.

58.28(4) Screening. The case manager shall perform screening to determine eligibility and disaster-related unmet needs.

58.28(5) Intake and assessment. The case manager shall perform intake and assessment procedures to triage disaster-related needs of eligible households.

a. A case manager shall conduct an assessment specifically seeking targeted information to identify a client's disaster-related needs.

b. An assessment should focus on planning for recovery and meeting recovery goals.

c. An assessment should be conducted in person, when feasible, and should follow all standards for confidentiality and engagement.

58.28(6) Recovery planning.

a. A recovery plan should outline tasks for both the client and case manager based on an assessment and documentation of needed services.

b. The plan should identify priority needs and connect the client with resources, establish benchmarks and goals to measure progress toward recovery, and outline a case closure procedure.

c. The plan should be a joint effort between the case manager and the client.

d. The case manager should explain the available options, the resource and recovery alternatives, and the support services offered by the case manager.

58.28(7) Action and advocacy. The case manager's role in recovery includes: providing, referring or arranging for needed services and resources; verifying unmet needs, completing documentation and checking duplication of benefits; and actively advocating for the client through presentation, participation in recovery groups and interface with government and nongovernment resource providers.

58.28(8) Monitoring. Monitoring the services allows the case manager to keep documents up to date, to determine if the chosen resources are providing the services needed, and to evaluate whether adjustments are needed.

58.28(9) Closure.

a. Closure procedures should be outlined in the recovery plan and the roles and responsibilities of the client and case manager clearly defined.

b. Case closure acknowledges the recovery goals achieved, recognizes the progress made toward unmet goals, and identifies needed resources to continue progress.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.29(29C) Planning and training. Training shall adhere to the disaster case management criteria, as prescribed by the federal Administration for Children and Families, and follow the disaster case management guidelines as designed by the Iowa disaster human resource council or the approved rules of the department. The department shall request from the executive council of the state of Iowa funds to perform training in disaster case management as requested and required to prepare for disaster response.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.30(29C) Payment for services.

58.30(1) The department will negotiate payment with the contracted entity when the contract is established. Payment will be based on the contracted entity's actual direct and indirect costs.

58.30(2) The department will accept the contracted entity's federally approved indirect cost rates as required by the federal Office of Management and Budget (OMB).

58.30(3) The local administrative entity may draw down grant funding to pay valid claims on at least a weekly basis.

58.30(4) Exhaustion of funds. The program shall be discontinued when the funds available for the program have been exhausted. The department will notify the contracted entity of the total available funds for the IDCM program once funds have been approved by the executive council. To ensure equitable treatment, assistance shall be approved on a first-come, first-served basis until all funds have been exhausted.

[ARC 3058C, IAB 5/10/17, effective 7/1/17]

441—58.31(29C) Contested cases.

58.31(1) Reconsideration.

a. The household may request reconsideration of decisions regarding eligibility.

b. To request reconsideration, the household shall submit a written request to the DHS Division of Field Operations—Emergency Assistance, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the letter notifying the household of the contracted entity's decision.

c. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.31(2) Appeal. The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.
[ARC 3058C, IAB 5/10/17, effective 7/1/17]

These rules are intended to implement Iowa Code sections 234.6 and 29C.20B.

441—58.32 to 58.40 Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS
Rescinded IAB 5/10/17, effective 7/1/17

441—58.41 to 58.50 Reserved.

DIVISION IV
IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM
Rescinded IAB 5/10/17, effective 7/1/17

441—58.51 to 58.60 Reserved.

DIVISION V
TICKET TO HOPE PROGRAM
Rescinded IAB 5/10/17, effective 7/1/17

441—58.61 to 58.68 Reserved.

- [Filed emergency 10/12/90 after Notice 8/22/90—published 10/31/90, effective 11/1/90]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
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- [Filed ARC 7830B (Notice ARC 7642B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]
- [Filed ARC 8007B (Notice ARC 7604B, IAB 3/11/09), IAB 7/29/09, effective 9/2/09]
- [Filed ARC 8640B (Notice ARC 8460B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]
- [Filed Emergency ARC 9130B, IAB 10/6/10, effective 9/15/10]
- [Filed Emergency ARC 9128B, IAB 10/6/10, effective 10/1/10]
- [Filed ARC 9313B (Notice ARC 9131B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
- [Filed ARC 9312B (Notice ARC 9129B, IAB 10/6/10), IAB 12/29/10, effective 3/1/11]

[Filed ARC 1353C (Notice ARC 1257C, IAB 12/25/13), IAB 3/5/14, effective 5/1/14]
[Filed ARC 3058C (Notice ARC 2898C, IAB 1/18/17), IAB 5/10/17, effective 7/1/17]
[Filed ARC 5596C (Notice ARC 5471C, IAB 2/24/21), IAB 5/5/21, effective 7/1/21]

TITLE VIII
MEDICAL ASSISTANCE
CHAPTER 73
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding.

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.

441—73.1(249A) Definitions.

“Behavioral health services” means mental health and substance use disorder treatment services.

“Capitated payment” means a monthly payment to the contractor on behalf of each enrollee for the provision of health services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

“Choice counseling” means the provision of unbiased information on managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

“Claim” means a formal request for payment for benefits received or services rendered.

“Clean claim” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

“CMS” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“Code of Federal Regulations (CFR)” means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

“Community-based case management” means a collaborative process of planning, facilitation, and advocacy for options and services to meet a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

“Contract” means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

“Covered services” means physical health, behavioral health and long-term care services set forth in rule 441—73.5(249A).

“Department” means the Iowa department of human services.

“Discharge planning” means the process, which begins at admission, of determining an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Emergency medical condition” means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

“EMTALA” means the Emergency Medical Treatment and Active Labor Act.

“Enrollee” means a hawki, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

“Enrollment broker” means the entity the department uses to enroll persons in a managed care organization. The enrollment broker must be conflict free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to October 16, 2015.

“Hawki program” means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

“Health maintenance organization” means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

“HIP” means the health insurance premium payment program.

“Home- and community-based services (HCBS)” means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

“Incident reporting” means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

“Insolvency” means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business or when the liabilities of the entity exceed its assets.

“Iowa Health and Wellness Plan” means the medical assistance program set forth in 441—Chapter 74.

“Level of care” means an evaluation to determine and establish an individual’s need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future.

“Long-term care (LTC)” or *“long-term services and supports (LTSS)”* means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID),

state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

“Managed care organization (MCO)” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“Mandatory enrollment” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“Medical loss ratio (MLR)” means the percentage of capitation payments that is used to pay medical expenses.

“Medically necessary services” means those covered services that are, under the terms and conditions of the contract, determined through contractor utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member’s physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

“Medical records” means all medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“Member” means any person determined by the department to be eligible for the hawki program, the Iowa Health and Wellness Plan, or the Medicaid program.

“Money Follows the Person (MFP) Rebalancing Demonstration Grant” means a federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

“Needs-based eligibility” means an evaluation to determine and establish an individual’s need for habilitation services.

“Network” or *“provider network”* means a group of participating health care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health care services.

“Out-of-network provider” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

“PACE” means the program for all-inclusive care for the elderly.

“Participating providers” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

“Passive enrollment process” means the process by which the department assigns a member to a managed care organization and which, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care organizations.

“PMIC” means a psychiatric medical institution for children.

“Prior authorization” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“*Warm transfer*” means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—73.2(249A) Contracts with a managed care organization.

73.2(1) The department may enter into a contract with a managed care organization licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as defined in rule 441—73.6(249A).

73.2(2) The department shall determine that the managed care organization meets the following requirements:

a. The managed care organization shall make available the services it provides to enrollees as established in the contract.

b. The managed care organization shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the managed care organization’s debts if the managed care organization becomes insolvent. The managed care organization shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

73.2(3) If not already accredited, the managed care organization must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the managed care organization must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with insurance division rules set forth in 191—Chapter 40.

73.2(4) The contract shall meet the following minimum requirements. The contract shall:

a. Be in writing.

b. Specify the duration of the contract period.

c. List the services which must be covered.

d. Describe service access and provide access information.

e. List conditions for nonrenewal, termination, suspension, and modification.

f. Specify the method and rate of reimbursement.

g. Provide for disclosure of ownership and subcontracted relationships.

h. Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the managed care organization, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

i. Specify appeal and grievance rights.

j. Specify all operational and service delivery expectations.

k. Specify reporting requirements.

l. Specify requirements for utilization management and quality improvement.

m. Specify requirements for program integrity.

n. Specify termination requirements and assessment of penalties.

o. Require managed care organizations and the fee-for-service Medicaid program to utilize a uniform prior authorization process. The process will include forms, information requirements, and time frames.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4847C, IAB 1/1/20, effective 6/29/20]

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All hawki program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid

members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

- a. Members who are medically needy as defined at 441—subrule 75.1(35).
- b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).
- c. Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).
- d. Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).
- e. Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).
- f. Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).
- g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

73.3(3) Enrollment process. The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to May 6, 2016.

a. *General.* Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. *Passive assignment.* Effective no earlier than the first day of the month of the member's application to Medicaid, the member shall be assigned to a managed care organization using the department's passive enrollment process and offered the opportunity to choose from the available managed care organizations within a time frame specified in the passive assignment letter.

c. *Request to change enrollment.* An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

d. *Ongoing enrollment.* Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

e. *Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

73.3(4) Benefit reimbursement prior to enrollment.

a. Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(4) "b," the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

b. The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods prior to the effective date of enrollment for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19]

441—73.4(249A) Disenrollment process.

73.4(1) Enrollee-requested disenrollment. An enrollee may request disenrollment with a managed care organization as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The managed care organization does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment shall be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the Hawki program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

d. The department has determined that participation in the HIPPP program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care organization-requested disenrollment.* A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.* The effective date of a department-approved disenrollment shall be no later than the first day of the second calendar month beginning after the month in which: (1) the enrollee requests disenrollment pursuant to subrule 73.4(1); (2) the department notifies the enrollee and managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the managed care organization shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.5(249A) Covered services.

73.5(1) Required services. A managed care organization shall provide:

a. For enrollees other than Iowa Health and Wellness Plan enrollees and hawki program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

- (1) Area education agency services.
- (2) Dental services not provided in an outpatient hospital setting.
- (3) Infant and toddler program services.
- (4) Local education agency services.
- (5) State of Iowa Veterans Home services.
- (6) Money Follows the Person Grant-funded services.

b. Services as set forth in 441—Chapter 74 for Iowa Health and Wellness Plan enrollees.

c. Services as set forth in 441—Chapter 86 for hawki program enrollees.

73.5(2) Community-based case management service. The managed care organization is required to provide services that meet requirements specified in the contract and in 441—Chapter 90.

73.5(3) Health home services. The managed care organization is required to provide services that meet the requirements specified in 441—subrule 78.53(1) and as specified in the contract.

73.5(4) Value-added services. A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, psychiatric medical institutions for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

73.6(2) The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The managed care organization shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, 7 days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

a. Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.

b. Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination, as defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

73.7(3) The managed care organization shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

b. Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.8(249A) Access to service.

73.8(1) The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, 7-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the managed care organization's provider network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

73.8(3) Continuity of care. The managed care organization shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The managed care organization shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. Member helpline. The managed care organization shall maintain a dedicated toll-free member services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal managed care organization departments, such as to care coordinators.

b. Nurse call line. The managed care organization shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, 7 days a week from trained medical professionals.

73.8(5) An enrollee's primary care provider shall be responsible for providing preventative and primary health care to the enrollee; for initiating referrals for specialist care, where appropriate; and for maintaining the continuity of patient care. Primary care providers may be physicians, advanced

registered nurse practitioners, or physician assistants, licensed and practicing in accordance with state law.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4392C, IAB 4/10/19, effective 6/1/19]

441—73.9(249A) Incident reporting. The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.10(249A) Discharge planning. The managed care organization shall establish policies and procedures, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.11(249A) Level of care assessment and annual reviews. The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

73.11(1) Initial level of care assessment. Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(2) Annual continued stay reviews, continued care reviews and redeterminations. When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the IME medical services unit for determination of level of care or needs-based eligibility.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.12(249A) Appeal of managed care organization actions. The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

73.12(1) Managed care organization appealable actions. Managed care organization actions that may be appealed include:

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.
- f. For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

73.12(2) Appeal process. The managed care organization appeal process shall be approved by the department and shall:

- a. Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.
- b. Require acknowledgment of the receipt of a request for an appeal within three working days.
- c. Allow for participation by the enrollee and the provider.
- d. Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.
- e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.
- f. Ensure that the review will be made by qualified professionals who were not involved with the original action.

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 3667C, IAB 3/14/18, effective 2/14/18]

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.14(249A) Continuation of benefits. The managed care organization shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to October 16, 2015.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- a. The enrollee withdraws the appeal request;
- b. Ten days pass after the MCO mailed the notice providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten-day time frame, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or
- c. The time period or service limits of a previously authorized service have been met.

73.14(2) If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization or the state fair hearing officer

reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the managed care organization must pay for these services.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.15(249A) Grievances. The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.16(249A) Written record. All enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions. The managed care organization's written procedures for the review of managed care organization decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.18(249A) Records and reports.

73.18(1) Records system. The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, throughout the course of the contract. The records system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of decisions made by the managed care organization, based upon medical necessity.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the managed care organization including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) Content of individual treatment record. The managed care organization shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015. Beginning January 1, 2021, the managed care organization shall require use of an electronic visit verification system for personal care services.

73.18(3) Confidentiality of health care, mental health care, and substance abuse information. The managed care organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.
[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, that pertain to services performed and the determination of amounts paid under

the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.20(249A) Marketing. Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.21(249A) Enrollee education.

73.21(1) Use of services. The managed care organization shall provide written information to all enrollees on the use of services the managed care organization is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of managed care organization decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) Outreach to members with special needs. The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual or hearing impairments.

73.21(3) Patient rights and responsibilities. The managed care organization shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.22(249A) Payment to the managed care organization.

73.22(1) Capitation rate. In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms defined in the managed care contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act, the health insurance providers fee. This capitation rate, inclusive of the amounts withheld and the health insurance providers fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the managed care organization meets metrics defined in the managed care contract.

73.22(2) Determination of rate. The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to October 16, 2015, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) Third-party liability. If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

73.22(4) Medical loss ratio. The managed care organization shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the managed care organization.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.23(249A) Claims payment by the managed care organization.

73.23(1) The managed care organizations shall pay or deny:

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

73.23(2) Limits on payment responsibility for services.

a. The managed care organization is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The managed care organization has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided at rule 441—73.7(249A).

73.23(3) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.24(249A) Quality assurance. The managed care organization shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.25(249A) Certifications and program integrity. The managed care organization shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code section 249A.4, 2015 Iowa Acts, Senate File 505, section 12, and 2019 Iowa Acts, House File 766, section 63.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed Emergency After Notice ARC 3667C (Notice ARC 3514C, IAB 12/20/17), IAB 3/14/18, effective 2/14/18]

[Filed ARC 4392C (Notice ARC 4258C, IAB 1/30/19), IAB 4/10/19, effective 6/1/19]

[Filed ARC 4429C (Notice ARC 4289C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]

[Filed ARC 4847C (Notice ARC 4673C, IAB 9/25/19), IAB 1/1/20, effective 6/29/20]

[Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]

[Filed ARC 5597C (Notice ARC 5437C, IAB 2/10/21), IAB 5/5/21, effective 7/1/21]

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

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

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

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

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

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

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

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

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

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

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

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

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

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

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

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

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

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

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

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

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

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

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

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

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

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

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

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

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

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

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

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

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

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the

department. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

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

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

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

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

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

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

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

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

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

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

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

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

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

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

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

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

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

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

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

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

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

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

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

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21]

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

78.2(1) Qualified prescriber. All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders shall be available for audit by the department.

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

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

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

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

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

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

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

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

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

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

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

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

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

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

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

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

(8) Drugs prescribed for fertility purposes.

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

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

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

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

78.2(5) Nonprescription drugs.

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 81 mg, chewable
Aspirin tablets 81 mg, 325 mg, and 650 mg oral
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaiifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Levonorgestrel 1.5 mg
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Vitamins, single and multiple with prior authorization
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

78.2(6) *Quantity prescribed.*

a. *Quantity prescribed.* When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. *Prescription refills.*

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

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

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

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Recipient selection and education.

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

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

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

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

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

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

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

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

The team should consist of:

A surgeon director.

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

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

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

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

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

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

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

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.
Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.
Pharmaceutical services.
Physical therapy.
Psychiatry.
Psycho-social.

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

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

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

c. *Experience and survival rates.*

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must

specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

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

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

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

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

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

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

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

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

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

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

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

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

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level

of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
 1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.
 2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.
 3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.
- (5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.
- (6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

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

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

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

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

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

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) "a"(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

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

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3) "c")

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

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

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

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

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

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

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

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

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

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) “c”)

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) Adjunctive general services. Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) Orthodontic services to members 21 years of age or older. Orthodontic procedures are not covered for members 21 years of age or older.

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.

- d. Shoe padding when appliances are not practical.
- e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f. Rams horn (hypertrophic) nails.
- g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

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

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a.* Corrected curve lenses, unless clinically contraindicated.
- b.* Standard plastic, plastic and metal combination, or metal frames.
- c.* Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(4))

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

- a.* Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b.* Glasses for occupational eye safety.
- c.* A second pair of glasses or spare glasses.
- d.* Cosmetic surgery and experimental medical and surgical procedures.
- e.* Sunglasses.
- f.* Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

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

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

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

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

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

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

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

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

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

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

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

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

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

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

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

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

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

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

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

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

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

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

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

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

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

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or

housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

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

78.9(8) *Medical social services.* Rescinded IAB 3/29/17, effective 5/3/17.

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

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

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

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

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

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

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

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

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

- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

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

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

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

a. Definitions.

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

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

Private duty nursing or personal care services do not include:

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

6. Homework assistance.

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

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

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21]

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

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

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

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

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

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

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

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)“k” for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)“*n*” for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

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

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)“*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See 78.10(5)“*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)“*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)“*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)“*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5)“*b*” and 78.10(5)“*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)“*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)“a” and 78.10(2)“c.”

Patient lift. See 78.10(5)“h” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)“f” for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

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

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;

3. Positioning accessories;
 4. Specialized skin protection seat and back cushions; and
 5. Anti-rollback devices.
- (3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:
1. Lap belt or safety belt;
 2. Battery charger, single mode;
 3. Complete set of tires/wheels and casters, any type;
 4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
 5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
 6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
 7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
 8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 10. Non-expandable controller or standard proportional joystick (integrated or remote); and
 11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).
- (4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
 2. Elevating legrest;
 3. Angle adjustable footplates;
 4. Adjustable height armrests; and
 5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).
- (5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.
- 78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.
- a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.
 - b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:
 - (1) Artificial eyes.
 - (2) Artificial limbs.
 - (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
 - (4) Hearing aids. See rule 441—78.14(249A).

- (5) Orthotic devices. See 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
 - 1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
 - 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

- Catheter (indwelling Foley).
- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
- Dialysis supplies.
- Disposable catheterization trays or sets (sterile).
- Disposable irrigation trays or sets (sterile).
- Disposable saline enemas (e.g., sodium phosphate type).
- Dressings.
- Elastic antiembolism support stocking.
- Enema.
- Hearing aid batteries.
- Incontinence products (for members three years of age and older).
- Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
- Ostomy appliances and supplies.
- Respirator supplies.
- Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Rescinded IAB 12/30/20, effective 3/1/21.

e. DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

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

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged

from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

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

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

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

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

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

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

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

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

78.12(1) Definitions.

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

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Family training services shall:

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

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

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

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

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

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

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

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

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

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

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

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

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

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

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

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

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

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

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

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

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

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)“b.”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

- (1) The patient is at risk for exclusion from normative community activities or residence.
- (2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- (3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.

A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical,

functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

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

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

- (1) High-risk medical conditions.
- (2) High-risk sexual behavior.
- (3) Smoking cessation.
- (4) Alcohol usage education.
- (5) Drug usage education.
- (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer.

Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Integrated health home” means the provision of services to enrolled members as described in subrule 78.53(1).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to

operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

e. Plan for service. The department has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) The member’s comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member’s needs.

(2) The member’s habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical

services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member’s rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member’s interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member’s needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member's interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,

(12) Assistance with developing and maintaining natural relationships in the community,
(13) Assistance with identifying and using natural supports,
(14) Assistance with accessing financial literacy and benefits education,
(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) "a"(1). This time limit can be extended as stated in paragraphs 78.27(9) "e"(1) "1" through "6." If the criteria in paragraphs 78.27(9) "e"(1) "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).

3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)“a”(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
 2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
 3. Identification of the long-term supports necessary for the individual to operate the business.
- b. Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member’s personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider’s organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
 2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
 3. Ongoing benefits education and support.
- (6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member’s comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member’s residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

f. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) “l.”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) “f.”

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) “a.”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2) “c”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) “m.”

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) “c.”

k. DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5) “e.”

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) “n.”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) “g.”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) “h.”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) “i.”

- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) “*j.*”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs, subject to the requirements of 78.10(2) “*d.*”

78.28(2) Notwithstanding the provisions of 78.28(1) “*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a.* Buprenorphine,
- b.* Buprenorphine and naloxone combination,
- c.* Methadone,
- d.* Naltrexone, and
- e.* Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

- (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “*b.*”
- (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “*d.*”
- (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “*e.*”
- (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “*f.*”
- (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) “*g.*”

b. The following prosthetic services:

- (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*b.*”
- (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*d.*”
- (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*c.*”
- (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*e.*”
- (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) “*k.*”
- (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) “*l.*”
- (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) “*m.*”
- (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) “*n.*”

c. The following orthodontic services:

- (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “*a.*”
- (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “*b.*”
- (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “*c.*”

d. The following restorative services:

- (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “*d*”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) "d"(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) "d."

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) "g."

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7) "d"(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

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

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

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

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12) "a," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational

or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs

are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

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

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and

audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children’s mental health waiver.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

- a. Components of the service include, but are not limited to:
 - (1) Observation and reporting of physical or emotional needs.
 - (2) Helping a client with bath, shampoo, or oral hygiene.
 - (3) Helping a client with toileting.
 - (4) Helping a client in and out of bed and with ambulation.
 - (5) Helping a client reestablish activities of daily living.
 - (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
 - (7) Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
 - (8) Accompaniment to medical services or transport to and from school.
- b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency’s Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.
- c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per

day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.

- (2) Bathing, shampooing, hygiene, and grooming.

- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
 - (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
 - (8) Minor wound care.
 - (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
 - (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
 - (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
 - (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.
- g. Skilled services.* Covered skilled service activities are limited to help with the following activities:
- (1) Tube feedings of members unable to eat solid foods.
 - (2) Intravenous therapy administered by a registered nurse.
 - (3) Parenteral injections required more than once a week.
 - (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
 - (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
 - (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
 - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
 - (8) Colostomy care.
 - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
 - (10) Postsurgical nursing care.
 - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
 - (12) Preparing and monitoring response to therapeutic diets.
 - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
 - (2) Any activity that the member is able to perform.
 - (3) Costs of food.
 - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
 - (5) Exercise that does not require skilled services.
 - (6) Parenting or child care for or on behalf of the member.
 - (7) Reminders and cueing.
 - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
 - (9) Transportation costs.
 - (10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

- b.* Only the following modifications are covered:
- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
 - (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
 - (3) Grab bars and handrails.
 - (4) Turnaround space adaptations.
 - (5) Ramps, lifts, and door, hall and window widening.
 - (6) Fire safety alarm equipment specific for disability.
 - (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
 - (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
 - (9) Keyless entry systems.
 - (10) Automatic opening device for home or vehicle door.
 - (11) Special door and window locks.
 - (12) Specialized doorknobs and handles.
 - (13) Plexiglas replacement for glass windows.
 - (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
 - (15) Motion detectors.
 - (16) Low-pile carpeting or slip-resistant flooring.
 - (17) Telecommunications device for the deaf.
 - (18) Exterior hard-surface pathways.
 - (19) New door opening.
 - (20) Pocket doors.
 - (21) Installation or relocation of controls, outlets, switches.
 - (22) Air conditioning and air filtering if medically necessary.
 - (23) Heightening of existing garage door opening to accommodate modified van.
 - (24) Bath chairs.
- c.* A unit of service is the completion of needed modifications or adaptations.
- d.* All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e.* Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
- h.* Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

- a.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
- (1) The required components of the system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
6. Supported community living.
7. Supported employment.
8. Transportation.

(6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.

3. Specialized medical equipment.
4. Transportation.

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)"d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.

24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13) "b" (11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) "d." The savings plan shall meet the requirements in paragraph 78.34(13) "f."

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community

for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet (Form 470-4429) or use Form 470-4429. All other employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)"m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a.* Observation and reporting of physical or emotional needs.
- b.* Helping a client with bath, shampoo, or oral hygiene.
- c.* Helping a client with toileting.
- d.* Helping a client in and out of bed and with ambulation.
- e.* Helping a client reestablish activities of daily living.
- f.* Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g.* Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "*f*" and the skilled activities listed in paragraph 78.37(15) "*g*." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining

access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8)“f” and the skilled activities listed in paragraph 78.38(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 3552C**, IAB 1/3/18, effective 2/7/18; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 5597C**, IAB 5/5/21, effective 7/1/21]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)"f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) Vaccines administered to children. Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) Vaccines administered to adults. Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 5175C, IAB 9/9/20, effective 6/1/21]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present

barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

- 1. An in-home medical communications transceiver.
- 2. A remote, portable activator.
- 3. A central monitoring station with backup systems staffed by trained attendants at all times.
- 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

- 1. A portable communications transceiver or transmitter to be worn or carried by the member.
- 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be

reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) Family counseling and training services. Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) Prevocational services. Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) Behavioral programming. Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)“f” and the skilled activities listed in paragraph 78.43(13)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical

care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5597C**, IAB 5/5/21, effective 7/1/21]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)“f” and the skilled activities listed in paragraph 78.46(1)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child’s needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child’s strengths and preferences;
 - (2) Consider the child’s physical and social environment;
 - (3) Specify goals of providing services to the child; and
 - (4) Specify actions to address the child’s medical, social, educational, and other service needs.
- These actions may include activities such as ensuring the active participation of the child and working with the child or the child’s authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) Child's eligibility. Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) Delivery of services. Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) Covered services. Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

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

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Coordination services. Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5305C, IAB 12/2/20, effective 2/1/21]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) Covered services. Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:
 - (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
 - (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
 - (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.
- b. Care coordination, which means assisting members with:
 - (1) Medication adherence;
 - (2) Chronic disease management;
 - (3) Appointments, referral scheduling, and reminders; and
 - (4) Understanding health insurance coverage.
- c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:
 - (1) Supporting health management;
 - (2) Improving disease control; and
 - (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
 - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
 - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:

- (1) Communicating with and advocating for the member or family for the assessment of care decisions;
- (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
- (3) Increasing health literacy and self-management skills; and
- (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
 1. Having a body mass index (BMI) over 25 for an adult, or
 2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23). [ARC 2166C, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Brain injury” means a diagnosis in accordance with rule 441—83.81(249A).

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“Intermittent community-based neurobehavioral rehabilitation services” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Neurobehavioral rehabilitation” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“Standardized assessment” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member's managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

- (8) Health and wellness management including dietary and nutritional programming;
 - (9) Progressive physical strengthening, fitness and retraining;
 - (10) Assistance with obtaining and use of assistive technology;
 - (11) Sobriety support development;
 - (12) Assistance with the self-identification of antecedent triggers;
 - (13) Assistance with preparation for transition to less intensive services including accessing the community;
 - (14) Flexibility in programming to meet individual needs;
 - (15) Assistance with re-learning coping and compensatory strategies;
 - (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
 - (17) Support and assistance with obtaining legal consultation and services;
 - (18) Assistance with community accessibility and safety;
 - (19) Assistance with re-learning household maintenance;
 - (20) Assistance with recreational and leisure skill development;
 - (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
 - (22) Opportunities to learn about brain injury and individual needs following brain injury;
 - (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
 - (24) Assistance with pursuit of education and employment goals;
 - (25) Protective oversight in the residential setting and community;
 - (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
 - (27) Transitional support and training;
 - (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
 - (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.
- c.* Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:
- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
 - (2) Modifying or adapting the member's environment to improve overall functioning;
 - (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
 - (4) Behavioral supports;
 - (5) Assistance with obtaining and use of assistive technology;
 - (6) Assistance with the self-identification of antecedent triggers;
 - (7) Flexibility in programming to meet the member's individual needs;
 - (8) Assistance with re-learning coping and compensatory strategies;
 - (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
 - (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
 - (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
 - (12) Transitional support and training;
 - (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.
- d.* Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.
- e.* Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

- (1) The time elapsed from referral to rehabilitation treatment plan development;
- (2) The continuity of treatment;
- (3) The length of stay per member;
- (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
- (5) Gaps in service;
- (6) The results achieved;
- (7) Member and stakeholder satisfaction;
- (8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;
- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.56(5) Documentation standards. Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician.

Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
 - (9) Discipline of the person providing the service.
 - (10) Certification period.
 - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
 - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
- 78.57(7)** Nursing, personal care, and psychosocial services do not include:
- a. Services provided to members aged 21 and older.
 - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
 - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
 - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
 - e. Transportation services.
 - f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
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¹ Two ARCs

² Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

⁴ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁵ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁶ Two ARCs

⁷ Two ARCs

⁸ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

⁹ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

¹⁰ Two or more ARCs

¹¹ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

¹² May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

¹³ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

- ¹⁴ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.
- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Substantial gainful activity” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payments” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. Rescinded IAB 1/2/19, effective 2/6/19.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) “b.”

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “*b*” and 75.5(4) “*c*” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member’s need for service based on the member’s needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1) “*d*” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member’s service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,792.65	\$959.50	\$3,742.93

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) (state plan private duty nursing or personal care services for persons aged 20 and under) shall be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member’s case manager no earlier than two months before, and no later than six months after, the member’s twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member’s waiver budget shall be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted managed care organization during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department shall determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services shall become effective on the later of the first day of the month of the member’s twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget shall extend up to the first of the month following the member's twenty-fifth birthday and shall remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4209C, IAB 1/2/19, effective 2/6/19; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange

services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) “a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) “c”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97. [ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent

support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) “b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Interdisciplinary team” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.
- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

- a. Sixty-five years of age or older.
- b. A resident of the state of Iowa.
- c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “b” and 75.5(4) “c” shall be applied.
- d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

- e. Determined to need services as described in subrule 83.22(2).
- f. Rescinded IAB 10/11/06, effective 10/1/06.
- g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.
2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.

2. The funding source for the service.

3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) "d," indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which

indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- d. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Electronic visit verification system*” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.
- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- c. An individualized care plan that identifies support needs.
- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Be diagnosed by a physician as having AIDS or HIV infection.
- b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“b” shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager shall review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1) "b" and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,876.80.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical

institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) “b” or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.” [ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“Client participation” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“Counseling” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided not more than 52 hours per month.

“Maintenance needs” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social

work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.

8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a person-centered, outcome-based plan of services which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

- (5) Not reside in a medical institution.
 - i.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
 - j.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.
 - k.* To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - l.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).
 - m.* For residential-based supported community living services, meet all of the following additional criteria:
 - (1) Be less than 18 years of age.
 - (2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:
 1. Social history;
 2. Case history that includes previous placements and service programs;
 3. Medical history that includes major illnesses and current medications;
 4. Current psychological evaluations and consultations;
 5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
 6. Any current court orders in effect regarding the child;
 7. Any legal history;
 8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
 9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
 10. Whether the interdisciplinary team is in agreement with the proposed placement.
- (3) Either:
 1. Be residing in an ICF/ID;
 2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)"a"; or
 3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

- n.* For day habilitation, be 16 years of age or older.
- o.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) “*a*” shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant’s needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager’s control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor’s off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) Effective date of eligibility.

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.
- i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:
 - (1) Score on subsection 1A: Exceptional Medical Support Needs.
 - (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
 - (3) Sum total of standard scores on the following subsections:
 1. Subsection 2A: Home Living Activities;

2. Subsection 2B: Community Living Activities;
3. Subsection 2E: Health and Safety Activities; and
4. Subsection 2F: Social Activities.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“Adaptive” means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a brain injury aged 18 years or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Brain injury” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.

Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with a brain injury aged 17 years or under.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

“*Service coordination*” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the

Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member's managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) Need for services.

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care. Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) Securing a state payment slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S),

Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for six or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.
7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
8. The applicant has behaviors that put the applicant at risk.
9. The applicant has behaviors that put others at risk.
10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) "e"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) "e"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 4974C, IAB 3/11/20, effective 4/15/20; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income

maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1) "f," indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) *Redetermination.* A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) *Allowable services.* Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) *Service plan.* A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a physical disability aged 18 years to 64 years.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Guardian” means a guardian appointed in probate court for an adult.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services

unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“*h*,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$705.84 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) Securing a county payment slot. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) HCBS physical disability waiver waiting list. When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.103(249A) Application.

83.103(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person.

Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.

- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) Annual assessment. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.
 [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) *Reconsideration request to IME medical services unit.* Rescinded IAB 9/5/12, effective 11/1/12.
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“b.”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Electronic visit verification system*” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Integrated health home*” means the provision of services to enrolled members as described in 441—subrule 78.53(1).

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

- a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group;
- or
- b. Be eligible under the special income level (300 percent) coverage group; or
- c. Become eligible through application of the institutional deeming rules; or
- d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

- a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.
 - b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,006.34 per month.
 - c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.
 - d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.
 - e. A consumer may be enrolled in only one HCBS waiver program at a time.
- [ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.123(249A) *Application.* The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

- (1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or
- (2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review.

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) Termination. A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.
- e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) "a" and "b."

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 106
DEER HUNTING BY RESIDENTS
[Prior to 12/31/86, Conservation Commission[290] Ch 106]

571—106.1(481A) Licenses. When hunting deer, all hunters must have in their possession a valid deer hunting license and a valid resident hunting license and must have paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person while hunting deer shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while that person is deer hunting or tagging a deer.

106.1(1) Type of license.

a. General deer licenses. General deer licenses shall be valid for taking deer in one season selected at the time the license is purchased. General deer licenses shall be valid for taking deer of either sex except in Buena Vista, Calhoun, Cherokee, Clay, Dickinson, Emmet, Hamilton, Humboldt, Ida, Kossuth, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sac, Sioux, Webster, and Wright Counties during the first regular gun season when the general deer license will be valid for taking deer with at least one forked antler. Paid general deer licenses shall be valid statewide except where prohibited in deer population management zones established under 571—Chapter 105. Free general deer licenses shall be valid for taking deer of either sex only on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

b. Antlerless-deer-only licenses. Antlerless-deer-only licenses shall be valid for taking deer that have no forked antler. Paid antlerless-deer-only licenses shall be valid in one county or in one deer population management zone and in one season as selected at the time the license is purchased. Free and reduced-fee antlerless-deer-only licenses shall be valid on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

106.1(2) Bow season licenses. General deer and antlerless-deer-only licenses, paid or free, shall be valid in both segments of the bow season.

106.1(3) Regular gun season licenses. Paid general deer and antlerless-deer-only licenses shall be valid in either the first or the second regular gun season, as designated on the license. Free general deer licenses and antlerless-deer-only licenses shall be valid in both the first and second regular gun seasons.

106.1(4) Muzzleloader season licenses. General deer and antlerless-deer-only licenses, paid or free, shall be valid in either the early or the late muzzleloader season, as designated on the license.

106.1(5) November antlerless-deer-only licenses. Rescinded IAB 7/11/12, effective 8/15/12.

106.1(6) January antlerless-deer-only licenses. Rescinded IAB 7/1/20, effective 8/5/20.

106.1(7) Free and reduced-fee deer licenses for landowners and tenants. A maximum of one free general deer license, two free antlerless-deer-only licenses, and two reduced-fee antlerless-deer-only licenses may be issued to a qualifying landowner or eligible family member and a qualifying tenant or eligible family member. Eligibility for licenses is described in 571—106.12(481A). The free general deer license shall be available for one of the following seasons: the youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. One free antlerless-deer-only license shall be available for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. The second free antlerless-deer-only license shall be valid only for the January antlerless-deer-only season and will be available only if a portion of the farm unit lies within a county where paid antlerless-deer-only licenses are available during that season. Each reduced-fee antlerless-deer-only license shall be valid for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, or January antlerless-deer-only season. January antlerless-deer-only licenses will be available only if a portion of the farm unit is located in a county where paid antlerless-deer-only licenses are available in that season.

106.1(8) Antlerless-deer-only crossbow licenses for senior citizens. Persons 70 years old or older may obtain one paid antlerless-deer-only license valid statewide for taking antlerless deer with a crossbow. The license will be valid only during the bow season.

106.1(9) Deer hunting licenses for nonambulatory persons. The commission shall issue licenses in conformance with Iowa Code section 483A.8C. A person applying for this license must provide a completed form obtained from the department of natural resources. The application shall be certified by the applicant's attending physician with an original signature and declare that the applicant is nonambulatory using the criteria listed in Iowa Code section 483A.8C(4). A medical statement from the applicant's attending physician that specifies criteria met shall be on 8½" × 11" letterhead stationery. The attending physician shall be a currently practicing doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner.

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8255B, IAB 11/4/09, effective 12/9/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 5066C, IAB 7/1/20, effective 8/5/20]

571—106.2(481A) Season dates. Deer may be taken only during the following seasons:

106.2(1) Bow season. Deer may be taken in accordance with the type of license issued from October 1 through the Friday before the first Saturday in December and from the Monday following the third Saturday in December through January 10 of the following year.

106.2(2) Regular gun seasons. Deer may be taken in accordance with the type, season and zone designated on the license from the first Saturday in December and continuing for five consecutive days (first regular gun season) or from the second Saturday in December and continuing for nine consecutive days (second regular gun season).

106.2(3) Muzzleloader seasons. Deer may be taken in accordance with the type, season and zone designated on the license from the Saturday closest to October 14 and continuing for nine consecutive days (early muzzleloader season) or from the Monday following the third Saturday in December through January 10 of the following year (late muzzleloader season).

106.2(4) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.2(5) January antlerless-deer-only season. Rescinded IAB 7/1/20, effective 8/5/20.

[ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 5066C, IAB 7/1/20, effective 8/5/20]

571—106.3(481A) Shooting hours. Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

571—106.4(481A) Limits.

106.4(1) Bow season. The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(2) Muzzleloader seasons. The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(3) Regular gun seasons. The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

106.4(4) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.4(5) January antlerless-deer-only season. Rescinded IAB 7/1/20, effective 8/5/20.

106.4(6) Maximum annual possession limit. The maximum annual possession limit for a resident deer hunter is one deer for each legal license and transportation tag obtained.

[ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 5066C, IAB 7/1/20, effective 8/5/20]

571—106.5(481A) Areas closed to hunting. There shall be no open seasons for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly. There shall be no open seasons for hunting deer on all portions of rights-of-way on Interstate Highways 29, 35, 80 and 380.

571—106.6(481A) Paid deer license quotas and restrictions. Paid deer licenses, including antlerless-deer-only licenses, will be restricted in the type and number that may be purchased.

106.6(1) Paid general deer licenses. Residents may purchase no more than two paid general deer licenses, one for the bow season and one for one of the following seasons: early muzzleloader season, late muzzleloader season, first regular gun season, or second regular gun season. No more than 7,500 paid statewide general deer licenses will be sold for the early muzzleloader season. Fifty additional paid early muzzleloader season licenses will be sold through and will be valid only for the Iowa Army Ammunition Plant. There will be no quota on the number of paid general deer licenses issued in the bow season, late muzzleloader season, first regular gun season, or second regular gun season.

106.6(2) Paid antlerless-deer-only licenses. Paid antlerless-deer-only licenses have quotas for each county and will be sold for each county until quotas are reached.

a. Paid antlerless-deer-only licenses may be purchased for any season in counties where licenses are available, except as outlined in 106.6(2)“*b.*” A license must be used in the season, county or deer population management area selected at the time the license is purchased.

b. No one may obtain paid licenses for both the first regular gun season and second regular gun season regardless of whether the licenses are valid for any deer or antlerless deer only. Paid antlerless-deer-only licenses for the early muzzleloader season may only be purchased by hunters who have already purchased one of the 7,500 paid statewide general deer licenses. Hunters who purchase one of the 7,500 paid statewide general deer licenses for the early muzzleloader season may not obtain paid antlerless licenses for the first or second regular gun season.

c. Prior to September 15, a hunter may purchase one antlerless-deer-only license for any season for which the hunter is eligible. Beginning September 15, a hunter may purchase an unlimited number of antlerless-deer-only licenses for any season for which the hunter is eligible, as set forth in 106.6(2)“*b.*” until the county or population management area quotas are filled. Licenses purchased for deer population management areas will not count in the county quota.

106.6(3) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.6(4) January antlerless-deer-only licenses. Rescinded IAB 7/1/20, effective 8/5/20.

106.6(5) Free landowner/tenant licenses. A person obtaining a free landowner/tenant license may purchase any combination of paid bow and paid gun licenses available to persons who are not eligible for landowner/tenant licenses as described in 571—106.12(481A).

106.6(6) Antlerless-deer-only licenses. Paid antlerless-deer-only licenses will be available by county as follows:

County	Quota	County	Quota	County	Quota
Adair	1200	Floyd	100	Monona	850
Adams	1200	Franklin	0	Monroe	2250
Allamakee	3800	Fremont	200	Montgomery	500
Appanoose	2700	Greene	0	Muscatine	775
Audubon	0	Grundy	0	O’Brien	0
Benton	325	Guthrie	2150	Osceola	0
Black Hawk	0	Hamilton	0	Page	500
Boone	300	Hancock	0	Palo Alto	0
Bremer	300	Hardin	0	Plymouth	0
Buchanan	300	Harrison	850	Pocahontas	0
Buena Vista	0	Henry	925	Polk	1350

County	Quota	County	Quota	County	Quota
Butler	150	Howard	450	Pottawattamie	850
Calhoun	0	Humboldt	0	Poweshiek	200
Carroll	0	Ida	0	Ringgold	1400
Cass	400	Iowa	450	Sac	0
Cedar	775	Jackson	1100	Scott	200
Cerro Gordo	0	Jasper	775	Shelby	0
Cherokee	0	Jefferson	1500	Sioux	0
Chickasaw	375	Johnson	850	Story	150
Clarke	2400	Jones	1100	Tama	300
Clay	0	Keokuk	450	Taylor	1500
Clayton	4000	Kossuth	0	Union	1400
Clinton	400	Lee	1500	Van Buren	2100
Crawford	0	Linn	850	Wapello	1700
Dallas	1875	Louisa	675	Warren	2700
Davis	1700	Lucas	2500	Washington	1000
Decatur	2200	Lyon	0	Wayne	2700
Delaware	950	Madison	3000	Webster	0
Des Moines	800	Mahaska	475	Winnebago	0
Dickinson	0	Marion	1850	Winneshiek	2700
Dubuque	975	Marshall	150	Woodbury	300
Emmet	0	Mills	500	Worth	0
Fayette	2300	Mitchell	100	Wright	0

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 0830C, IAB 7/10/13, effective 8/14/13; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 2697C, IAB 8/31/16, effective 8/12/16; ARC 3098C, IAB 6/7/17, effective 7/12/17; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 4531C, IAB 7/3/19, effective 8/7/19; ARC 5066C, IAB 7/1/20, effective 8/5/20]

571—106.7(481A) Method of take. Permitted weapons and devices vary according to the type of season.

106.7(1) Bow season. Only longbow, compound, or recurve bows shooting broadhead arrows are permitted during the bow season. Arrows must be at least 18 inches long.

a. Crossbows, as described in 106.7(1) “*b*,” may be used during the bow season in the following two situations:

(1) By persons with certain afflictions of the upper body as provided in 571—15.22(481A); and

(2) By persons over the age of 70 with an antlerless-deer-only license as provided in Iowa Code section 483A.8B.

b. Crossbow means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical trigger and a working safety. Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead.

c. No explosive or chemical device may be attached to any arrow, broadhead or bolt.

106.7(2) Regular gun seasons. Only the following shall be used in the regular gun season: 10-, 12-, 16-, and 20-gauge shotguns shooting single slugs; any handgun or rifle as described in Iowa Code section 481A.48; and any muzzleloaders as described in subrule 106.7(3).

106.7(3) Muzzleloader seasons. Only muzzleloading rifles, muzzleloading muskets, muzzleloading pistols, and muzzleloading revolvers will be permitted for taking deer during the early muzzleloader season. During the late muzzleloader season, deer may be taken with a muzzleloading rifle,

muzzleloading musket, muzzleloading pistol, muzzleloading revolver, any handgun as defined in 106.7(2), crossbow as described in 106.7(1) “b,” or bow as described in 106.7(1). All muzzleloaders as described in this subrule shall only shoot a single projectile between .44 and .775 of an inch.

106.7(4) *November antlerless-deer-only season.* Rescinded IAB 7/11/12, effective 8/15/12.

106.7(5) *January antlerless-deer-only season.* Bows, crossbows, shotguns, muzzleloaders, rifles, and handguns as described in this rule may be used during the January antlerless-deer-only season.

106.7(6) *Prohibited weapons and devices.* The use of dogs, domestic animals, bait, firearms except as provided for in this chapter, crossbows except as provided in 106.7(1), automobiles, aircraft, or any mechanical conveyance or device, including electronic calls, is prohibited, except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. “Bait” means grain, fruit, vegetables, nuts, hay, salt, mineral blocks, or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. “Paraplegic” means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord. It shall be unlawful for a person, while hunting deer, to carry or have in possession a rifle except as provided in 106.7(2) or 106.7(3). A person in possession of a valid permit to carry weapons may carry a handgun while hunting. However, only handguns as described in 106.7(2) may be used to hunt deer and only when a handgun is a lawful method of take.

106.7(7) *Discharge of firearms from roadway.* No person shall discharge a rifle, including a muzzleloading rifle or musket, or a handgun from a highway while deer hunting. In addition, no person shall discharge a shotgun shooting slugs from a highway north of U.S. Highway 30. A “highway” means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

106.7(8) *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 106.2(2), unless such blind exhibits a solid blaze orange marking which is a minimum of 144 square inches in size and is visible in all directions. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term “blind” is defined as an enclosure used for concealment while hunting, constructed either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 3098C, IAB 6/7/17, effective 7/12/17; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 5601C, IAB 5/5/21, effective 6/9/21]

571—106.8(481A) Procedures to obtain licenses. All resident deer hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents, or online at www.iowadnr.com, or by calling the ELSI telephone ordering system.

106.8(1) *Licenses with quotas.* All paid deer hunting licenses for which a quota is established may be obtained from the ELSI system on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

106.8(2) *Licenses without quotas.* All deer hunting licenses that have no quota may be obtained from the ELSI system beginning August 15 through the last day of the hunting period for which a license is valid.

106.8(3) *Providing false information.*

a. Any person who provides false information about the person’s identity or eligibility for any paid or free landowner/tenant deer license and tag and who attests that the information is correct by accepting and signing the license or tag shall have the person’s hunting license revoked as a part of the sentencing for such criminal conviction, and the person shall not be issued a hunting license for one year pursuant to the authority of Iowa Code section 483A.24(2) “f” and rule 571—15.6(483A).

b. In addition to any legal penalties that may be imposed, the obtaining of a license in violation of this rule shall invalidate that deer license and transportation tag and any other deer hunting license and transportation tag obtained during the same year.

571—106.9(481A) Transportation tag. A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to one leg of each antlerless deer or on the main beam between two points, if present, on one of the antlers of an antlered deer in such a manner that the tag cannot be removed without mutilating or destroying the tag. This tag shall be attached to the carcass of the deer within 15 minutes of the time the deer carcass is located after being taken or before the carcass is moved to be transported by any means from the place where the deer was taken, whichever occurs first. No person shall tag a deer with a transportation tag issued to another person or with a tag that was purchased after the deer was taken. During the youth/disabled hunter season, bow season, early muzzleloader season and late muzzleloader season, the hunter who killed the deer must tag the deer by using the transportation tag issued in that person's name. During the first and second regular gun seasons and the January antlerless-deer-only season, anyone present in the hunting party may tag a deer with a tag issued in that person's name. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to the deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility or until the deer has been processed for consumption.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.10(481A) Youth deer and severely disabled hunts.

106.10(1) Licenses.

a. *Youth deer hunt.* A youth deer license may be issued to any Iowa resident who is not over 15 years old on the day the youth obtains the license. The youth license may be paid or free to persons eligible for free licenses. If the youth obtains a free landowner/tenant license, it will count as the one free general deer license for which the youth's family is eligible.

Each participating youth must be accompanied by an adult who possesses a regular hunting license and has paid the habitat fee (if the adult is normally required to have a hunting license and to pay the habitat fee to hunt). Only one adult may participate for each youth hunter. The accompanying adult must not possess a firearm or bow and must be in the direct company of the youth at all times.

A person may obtain only one youth general deer license but may also obtain any other paid or free general deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner with which other hunters obtain them, as described in 106.6(2).

b. *Severely disabled hunt.* Any severely disabled Iowa resident meeting the requirements of Iowa Code section 321L.1(8) may be issued one general deer license to hunt deer during the youth season. A person applying for this license must either possess a disability parking permit or provide a completed form from the department of natural resources. The form must be signed by a physician verifying that the person's disability meets the criteria defined in Iowa Code section 321L.1(8). The attending physician shall be currently practicing medicine and shall be a medical doctor, a doctor of osteopathy, a physician assistant, or a nurse practitioner. Forms are available online at www.iowadnr.gov, by visiting the DNR office at the Wallace State Office Building, Des Moines, Iowa, or any district office, or by calling (515)725-8200. A person between 16 and 65 years of age must also possess a regular hunting license and have paid the habitat fee to obtain a license (if normally required to have a hunting license and to pay the habitat fee to hunt). A severely disabled person obtaining this license may obtain any other paid and free general deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner by which other hunters obtain them, as described in 106.6(2).

106.10(2) Season dates. Deer of either sex may be taken statewide for 16 consecutive days beginning on the third Saturday in September. A person who is issued a youth deer hunting license and does not

take a deer during the youth deer hunting season may use the deer hunting license and unused tag during any subsequent deer seasons. The license will be valid for the type of deer and in the area specified on the original license. The youth must follow all other rules specified in this chapter for each season, including method of take. If the tag is filled during any of the seasons, the license will not be valid in subsequent seasons.

106.10(3) Shooting hours. Legal shooting hours will be one-half hour before sunrise to one-half hour after sunset each day regardless of weapon used.

106.10(4) Limits and license quotas. An unlimited number of licenses may be issued. The daily and season bag and possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.10(5) Method of take and other regulations. Deer may be taken with shotguns, bows, handguns, rifles, or muzzleloaders as permitted in 571—106.7(481A). Youth hunters using a handgun must be accompanied and under direct supervision throughout the hunt by a responsible person with a valid hunting license who is at least 21 years of age, with the consent of a parent or guardian. The responsible person with a valid hunting license who is at least 21 years of age shall be responsible for the conveyance of the pistol or revolver while the pistol or revolver is not actively being used for hunting. "Direct supervision" means the same as defined in Iowa Code section 483A.27A(4). All participants must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for obtaining licenses or hunting deer shall apply.

106.10(6) Procedures for obtaining licenses. Paid and free youth season licenses and licenses for severely disabled hunters may be obtained through ELSI beginning August 15 through the last day of the youth season.

[ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 3098C, IAB 6/7/17, effective 7/12/17; ARC 3831C, IAB 6/6/18, effective 7/11/18; ARC 5601C, IAB 5/5/21, effective 6/9/21]

571—106.11(481A) Deer depredation management. The deer depredation management program provides assistance to producers through technical advice and additional deer licenses and permits where the localized reduction of female deer is needed to reduce damage. Upon signing a depredation management agreement with the department, producers of agricultural or high-value horticultural crops may be issued deer depredation permits to shoot deer causing excessive crop damage. If immediate action is necessary to forestall serious damage, depredation permits may be issued before an agreement is signed. Further permits will not be authorized until an agreement is signed.

106.11(1) Method of take and other regulations. Legal weapons and restrictions will be governed by 571—106.7(481A). For deer shooting permits only, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93. The producer or designee must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122.

106.11(2) Eligibility. Producers growing typical agricultural crops (such as corn, soybeans, hay and oats and tree farms and other forestlands under a timber management program) and producers of high-value horticultural crops (such as Christmas trees, fruit or vegetable crops, nursery stock, and commercially grown nuts) shall be eligible to enter into depredation management agreements if these crops sustain excessive damage.

a. The producer may be the landowner or a tenant, whoever has cropping rights to the land.

b. Excessive damage is defined as crop losses exceeding \$1,000 in a single growing season, or the likelihood that damage will exceed \$1,000 if preventive action is not taken, or a documented history of at least \$1,000 of damage annually in previous years.

c. Producers who lease their deer hunting rights are not eligible for the deer depredation management program.

106.11(3) Depredation management plans. Upon request from a producer, field employees of the wildlife bureau will inspect and identify the type and amount of crop damage sustained from deer. If damage is not excessive, technical advice will be given to the producer on methods to reduce or prevent future damage. If damage is excessive and the producer agrees to participate, a written depredation management plan will be developed by depredation biologists in consultation with the producer.

a. The goal of the management plan will be to reduce damage to below excessive levels within a specified time period through a combination of producer-initiated preventive measures and the issuance of deer depredation permits.

(1) Depredation plans written for producers of typical agricultural crops may require preventive measures such as harassment of deer with pyrotechnics and cannons, guard dogs, and temporary fencing, as well as allowing more hunters, increasing the take of antlerless deer, and other measures that may prove effective.

(2) Depredation plans written for producers of high-value horticultural crops may include all of the measures in (1) above, plus permanent fencing where necessary. Fencing will not be required if the cost of a fence exceeds \$1,000.

(3) Depredation permits to shoot deer may be issued to Iowa residents to reduce deer numbers until long-term preventive measures become effective. Depredation permits will not be used as a long-term solution to deer damage problems.

b. Depredation management plans will normally be written for a three-year period with progress reviewed annually by the department and the producer.

(1) The plan will become effective when signed by the depredation biologist and the producer.

(2) Plans may be modified or extended if mutually agreed upon by the department and the producer.

(3) Depredation permits will not be issued after the initial term of the management plan if the producer fails to implement preventive measures outlined in the plan.

106.11(4) *Depredation permits.* Two types of permits may be issued under a depredation management plan.

a. Deer depredation licenses. Deer depredation licenses may be sold to resident hunters only for the regular deer license fee for use during one or more legal hunting seasons. Depredation licenses will be available to producers of agricultural and horticultural crops.

(1) Depredation licenses will be issued up to the number specified in the management plan.

(2) The landowner or an eligible family member, which shall include the landowner's spouse or domestic partner and juvenile children, may obtain one depredation license for each season established by the commission. No other individual may initially obtain more than three depredation licenses per management plan. When a deer is reported harvested on one of these licenses, then another license may be obtained.

(3) Depredation licenses will be valid only for hunting antlerless deer, regardless of restrictions that may be imposed on regular deer hunting licenses in that county.

(4) Hunters may keep any deer legally tagged with a depredation license.

(5) All other regulations for the hunting season specified on the license will apply.

(6) Depredation licenses will be valid only on the land where damage is occurring and the immediately adjacent property unless the land is within a designated block hunt area as described in subparagraph (7). Other parcels of land in the farm unit not adjacent to the parcels receiving damage will not qualify.

(7) Block hunt areas are areas designated and delineated by wildlife biologists of the wildlife bureau to facilitate herd reduction in a given area where all producers may not qualify for the depredation program or in areas of persistent deer depredation. Depredation licenses issued to producers within the block hunt area are valid on all properties within the delineated boundaries. Individual landowner permission is required for hunters utilizing depredation licenses within the block hunt area boundaries. Creation of a given block hunt area does not authorize trespass.

b. Deer shooting permits. Permits for shooting deer outside an established hunting season may be issued to producers of high-value horticultural crops when damage cannot be controlled in a timely manner during the hunting seasons (such as late summer buck rubs in an orchard and winter browsing in a Christmas tree plantation) and to other agricultural producers who have an approved DNR deer depredation plan, and on areas such as airports where public safety may be an issue.

(1) Deer shooting permits will be issued at no cost to the applicant.

(2) The applicant or one or more designees approved by the department may take all the deer specified on the permit.

(3) Permits available to producers of high-value horticultural crops or agricultural crops may be valid for taking deer outside of a hunting season depending on the nature of the damage. The number and type of deer to be killed will be determined by a department depredation biologist and will be part of the deer depredation management plan.

(4) Permits issued due to public safety concerns may be used for taking any deer, as necessary, to address unpredictable intrusion which could jeopardize public safety. Permits may be issued for an entire year (January 1 through December 31) if the facility involved signs an agreement with the department.

(5) All deer killed must be recovered and processed for human consumption.

(6) The times, dates, place and other restrictions on the shooting of deer will be specified on the permit.

(7) Antlers from all deer recovered must be turned over to the conservation officer within 48 hours. Antlers will be disposed of according to department rules.

(8) For out-of-season shooting permits, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93.

c. Depredation licenses and shooting permits will be issued in addition to any other licenses for which the hunters may be eligible.

d. Depredation licenses and shooting permits will not be issued if the producer restricts the legal take of deer from the property sustaining damage by limiting hunter numbers below levels required to control the deer herd. This restriction does not apply in situations where shooting permits are issued for public safety concerns.

e. A person who receives a depredation permit pursuant to this paragraph shall pay a \$1 fee for each license that shall be used and is appropriated for the purpose of deer herd population management, including assisting with the cost of processing deer donated to the help us stop hunger (HUSH) program administered by the commission and a \$1 writing fee for each license to the license agent.

106.11(5) Disposal. Rescinded IAB 7/16/08, effective 8/20/08.
[ARC 7921B, IAB 7/1/09, effective 8/5/09]

571—106.12(481A) Eligibility for free landowner/tenant deer licenses.

106.12(1) Who qualifies for free deer hunting licenses.

a. Owners and tenants of a farm unit and the spouse and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free deer licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

b. Juvenile child defined. “Juvenile child” means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

106.12(2) Who qualifies as a tenant. A “tenant” is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner’s family, including in some circumstances the landowner’s spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

106.12(3) What “actively engaged in farming” means. Landowners and tenants are “actively engaged in farming” if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

106.12(4) Landowners who qualify as active farmers. These landowners:

a. Are the sole operator of a farm unit (along with immediate family members), or

b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or

c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or

d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or

e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or

f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

106.12(5) *Landowners who do not qualify.* These landowners:

a. Use a farm manager or other third party to operate the farm, or

b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

106.12(6) *Where free licenses are valid.* A free license is valid only on that portion of the farm unit that is in a zone open to deer hunting. “Farm unit” means all parcels of land in tracts of two or more contiguous acres that are operated as a unit for agricultural purposes and are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. “Agricultural purposes” includes but is not limited to field crops, livestock, horticultural crops (e.g., from nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

106.12(7) *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free deer hunting licenses must register with the department before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

571—106.13(481A) Harvest reporting. Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

571—106.14(481A) Extension to the regular gun seasons. Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.8, 483A.8B, 483A.8C, 483A.24 and 483A.24B.

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MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
 [Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 1
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[Prior to 5/4/88, see 470—135.1 to 135.10]

653—1.1(17A,147) Definitions. The following definitions shall be applicable to the rules of the board of medicine:

“*Acupuncture*” shall mean a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

“*Acupuncturist*” shall mean a person licensed to practice acupuncture in this state.

“*Alternate member*” shall mean a person who is qualified under Iowa Code section 148.2A to substitute for a board member who is disqualified or becomes unavailable for any other reason for a contested case hearing. An alternate board member is deemed a member of the board only for the hearing panel(s) for which the alternate board member serves.

“*Board*” shall mean the board of medicine of the state of Iowa.

“*Department*” shall mean the Iowa department of public health.

“*Director*” shall mean the director of the department.

“*Disciplinary proceeding*” shall mean any proceeding under the authority of the board pursuant to which licensee discipline may be imposed.

“*License*” shall mean a certificate issued to a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

“*Licensee*” shall mean a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

“*Licensee discipline*” or “*discipline*” shall mean any sanction the board may impose upon its licensees for conduct which threatens or denies citizens of this state a high standard of professional care.

“*Malpractice*” shall mean any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care by a physician in the practice of the physician’s profession.

“*Medical practice Acts*” shall refer to Iowa Code chapters 147 and 148.

“*Order*” shall mean a requirement, procedure or standard of specific or limited application adopted by the board relating to any matter the board is authorized to act upon, including the professional conduct of licensees and the examination for licensure and licensure of any person under the laws of this state.

“*Peer review*” shall mean evaluation of professional services rendered by a professional practitioner.

“*Peer reviewer(s)*” shall mean one or more persons acting in a peer review capacity who have been appointed by the board for such purpose.

“*Physician*” shall mean a person licensed to practice medicine and surgery or osteopathic medicine and surgery under the laws of this state.

“*Practice of acupuncture*” means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medical concepts.

“*The practice of medicine and surgery*” shall mean holding one’s self out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition and who shall either offer or undertake, by any means or methods, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition. This rule shall not apply to licensed podiatrists, chiropractors, physical therapists, nurses, dentists, optometrists, acupuncturists, pharmacists, and other licensed health professionals who are exclusively engaged in the practice of their respective professions.

“*Prescription drugs*” means drugs, medicine and controlled substances which by law can only be prescribed for human use by persons authorized by law.

“*Profession*” shall mean medicine and surgery, osteopathic medicine and surgery, or acupuncture.

“*Respondent*” shall mean a licensee charged by the board in a complaint and statement of charges with violations of statutes or rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, or acupuncture.

“*Rule*” shall mean a regulation, requirement, procedure, or standard of general application prescribed by the board relating to either the administration or enforcement of Iowa Code chapters 147, 148, and 148E.

653—1.2(17A) Purpose of board. The purpose of the board is to administer and enforce the provisions of Iowa Code chapters 147, 148, 148E, and 272C with regard to the practice of medicine and surgery, osteopathic medicine and surgery, and acupuncture, including, but not limited to, the examination of applicants; determining the eligibility of applicants for licensure by examination or endorsement; the granting of permanent, temporary, resident or special licenses to physicians; determining the ineligibility of physicians to provide supervision to physician assistants; the investigation of violations or alleged violations of statutes and rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, and acupuncture; the imposition of discipline upon licensees as provided by statute or rule; and the operation of a licensee review committee for the purpose of evaluating and monitoring licensees who are impaired as a result of alcohol or drug abuse, dependency, or addiction, or by any mental or physical disorder or disability and who self-report or who are referred by the board to the committee.

653—1.3(17A) Organization of board. The board:

1.3(1) Makes policy relative to matters involving medical and acupuncture education, licensure, practice, and discipline.

1.3(2) Conducts business according to board-approved policy.

1.3(3) Elects a chairperson, vice chairperson and a secretary from its membership at the last regular board meeting prior to May 1 or at another date in April scheduled by the board.

1.3(4) A majority of the members of the board shall constitute a quorum. Official action, including filing of formal charges or imposition of discipline, requires a majority vote of members present.

1.3(5) Has the authority to:

a. Administer the statutes and rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, the practice of acupuncture by acupuncturists, and the practice of genetic counseling by genetic counselors.

b. Review or investigate, upon receipt of a complaint or upon its own initiation, based upon information or evidence received, alleged violations of statutes or rules which relate to the practice of medicine and surgery, osteopathic medicine and surgery, the practice of acupuncture by licensed acupuncturists, and the practice of genetic counseling by licensed genetic counselors.

c. Determine in any case whether an investigation or a disciplinary action is warranted.

d. Initiate and prosecute disciplinary proceedings.

e. Impose licensee discipline.

f. Request that the attorney general file appropriate court action for enforcement of the board’s authority relating to licensees or other persons who are charged with violating statutes or rules the board administers or enforces.

g. Establish and register peer reviewers.

h. Refer to one or more registered peer reviewers for investigation, review, and report to the board any complaint or other evidence of an act or omission which the board has reasonable grounds to believe may constitute cause for licensee discipline. However, the referral of any matter shall not relieve the board of any of its duties and shall not divest the board of any authority or jurisdiction.

i. Determine eligibility for license renewal and administer the renewal of licenses.

j. Establish and administer rules for continuing education and mandatory training requirements as a condition of license renewal.

k. Establish fees for examination, fees for the issuance of licenses and fees for other services provided by the board with the intention of producing sufficient revenue to cover the expenses involved with operation of the board and the board office.

l. Establish committees of the board, the members of which, except for the executive committee, shall be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include:

(1) Executive committee. The membership shall be composed of the elected officers of the board and two at-large members appointed by the chairperson. At least one public member shall be appointed to the executive committee. The executive committee duties may include, but are not limited to:

1. Guidance and supervision of the executive director.
2. Budgetary review and recommendations to the board.
3. Review and recommendations to the board on rules and legislative proposals.
4. Study and recommendations to the board on practice issues and policy.

(2) Screening committee. The committee reviews complaints and makes recommendations to the board on appropriate action including further investigation or referral to the board for closure.

(3) Licensure committee. Its duties may include:

1. Recommending appropriate action on completed applications for licensure.
2. Conducting interviews with applicants when appropriate.
3. Reviewing licensure examination matters.
4. Reviewing and recommending to the board appropriate changes in licensure application forms.
5. Reviewing and making recommendations to the board regarding volunteer physician applicants who wish to participate in the state-indemnified volunteer physician program and who are under investigation or who have or have had disciplinary action against a license in the present or in the past.

6. Making recommendations on licensure policy issues.

(4) Monitoring committee. The committee oversees the monitoring of licensees under board orders and makes recommendations to the board on these matters.

m. Establish the Iowa physician health committee as its licensee review committee.

n. Advise the director of the department of public health in evaluating potential candidates for the position of executive director, consult with the director in the hiring of the executive director, and review and advise the director on the performance of the executive director in the discharge of the executive director's duties.

o. Adopt administrative rules and pursue legislation where necessary to conduct the board's business.

p. Establish a pool of up to ten alternate board members to serve on a hearing panel when a sufficient number of board members is unavailable to hear a contested case.

1.3(6) Guide and direct a full-time executive director who:

a. Is not a member of the board.

b. Under the supervision of the director of the department of public health and the guidance or direction of the board performs administrative duties of the board including, but not limited to: staff supervision and delegation; administration and enforcement of the statutes and rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, the practice of acupuncture, and the practice of genetic counseling; issuance of subpoenas on behalf of the board or a committee of the board during the investigation of possible violations; and enunciation of policy on behalf of the board.

1.3(7) Establishes, in accordance with Iowa Code section 148.2A, a pool of alternate board members.

a. At the beginning of each fiscal year, the executive director presents a list of persons who are qualified under Iowa Code section 148.2A to serve as alternate board members for the year beginning September 1.

b. The executive director shall present the board-approved list of alternate board members to the governor for approval.

c. Once the governor approves an alternate board member, the executive director or designee may assign the approved member to hear a contested case when an approved number of board members is unavailable.

[ARC 5599C, IAB 5/5/21, effective 6/9/21]

653—1.4(17A) Official communications. All official communications, including submissions and requests, should be addressed to the Executive Director, Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, Iowa 50309-4686.

653—1.5(17A) Office hours. The office of the board is open for public business from 8 a.m. to 4:30 p.m., Monday to Friday of each week, except holidays.

653—1.6(17A) Meetings. The board shall meet at least six times per year. Dates and location of board meetings may be obtained from the board's office or on the board's website at www.medicalboard.iowa.gov.

Except as otherwise provided by statute, all board meetings shall be open, and the public shall be permitted to attend the meetings.

653—1.7(17A,147) Petition to promulgate, amend or repeal a rule.

1.7(1) An interested person or other legal entity may petition the board requesting the promulgation, amendment or repeal of a rule.

1.7(2) The petition shall be in writing, signed by or on behalf of the petitioner and contain a detailed statement of:

a. The rule that the petitioner is requesting the board to promulgate, amend or repeal. The petitioner shall indicate deletions to the current rule with brackets and additions to the current rule with underlining.

b. Facts in sufficient detail to show the reasons for the proposed action.

c. All propositions of law to be asserted by petitioner.

1.7(3) The petition shall be in typewritten or printed form, captioned BEFORE THE IOWA BOARD OF MEDICINE and shall be deemed filed when received by the executive director.

1.7(4) Upon receipt of the petition the executive director shall:

a. Mail within ten days a copy of the petition to any parties named in it. The petition shall be deemed served on the date of mailing to the last-known address of the party being served.

b. Advise petitioner that petitioner has 30 days within which to submit written views.

c. Schedule oral presentation of petitioner's view if the board so directs.

d. Within 60 days after date of submission of the petition, either deny the petition or initiate rule-making proceedings in accordance with Iowa Code chapter 17A.

1.7(5) In the case of a denial of a petition to promulgate, amend or repeal a rule, the board or its executive director shall issue an order setting forth the reasons in detail for denial of the petition. The order shall be mailed to the petitioner and all other persons upon whom a copy of the petition was served.

653—1.8(17A) Public hearings prior to the adoption, amendment or repeal of any rule.

1.8(1) *Scheduling a public hearing.* The board may at its discretion hold a public hearing, or it shall hold a public hearing upon the written request of at least 25 interested persons, a governmental subdivision, an agency, or an association of 25 persons.

a. If the board chooses to hold a public hearing, it will announce the date, time, and location in the Iowa Administrative Bulletin.

b. If the board has not scheduled a public hearing and a person or an organization wishes to request one, a written request for a public hearing shall be received by the executive director within 20 days after the notice of intended action has been published.

(1) The executive director shall schedule a public hearing if the request(s) meets the requirements of this rule.

(2) The executive director shall set the date, time, and location of the public hearing.

(3) The individual or organization requesting the public hearing shall be notified of the date, time, and location of the public hearing by certified mail.

1.8(2) *Proceedings at the public hearing.* The chairperson of the board shall serve as the presiding officer or appoint a presiding officer over the public hearing.

a. Any individual(s) may present either written or oral comments pertinent to the rule(s) for which the public hearing has been scheduled.

(1) Any individual(s) desiring to make written comments in advance of the hearing shall submit these comments to the executive director. The presiding officer shall accept written comments at the hearing.

(2) Any individual(s) desiring to make an oral presentation shall be present at the hearing and ask to speak.

b. The authority of the presiding officer during the public hearing includes:

- (1) Setting a time limit on oral presentations if necessary;
- (2) Excluding any individual(s) who may be either disruptive or obstructive to the hearing;
- (3) Ruling that the oral presentation or discussion is not pertinent to the hearing; and
- (4) Accepting any written testimony.

c. The conduct of the presiding officer during the public hearing shall include but need not be limited to:

- (1) Open the hearing and receive appearances.
- (2) Enter the notice of hearing into the public record.
- (3) Review rule(s) under adoption, amendment or repeal and provide rationale for the proposed action by the board.
- (4) Receive written and oral presentations.
- (5) Read into the official public record written comments which have been submitted.
- (6) Inform those individuals present that within 30 days of the date of hearing the board shall issue a written statement of the principal reasons for and against the rule it adopted, incorporating therein the reasons either for accepting or overruling considerations urged against the rule.
- (7) Adjourn the hearing.

653—1.9(17A) Declaratory orders.

1.9(1) *Petition for declaratory order.* Any person may file a petition with the board of medicine for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the board. A petition is deemed filed when it is received by the board office. The board shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board office with an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BOARD OF MEDICINE	
Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	} PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

- 1. A clear and concise statement of all relevant facts on which the order is requested.
- 2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
- 3. The questions petitioner wants answered, stated clearly and concisely.
- 4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
- 5. The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome.
- 6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
- 7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.

8. Any request by petitioner for a meeting provided for by 1.9(7).

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

1.9(2) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the board shall give notice of the petition to all persons not served by the petitioner pursuant to 1.9(6) "c" to whom notice is required by any provision of law. The board may also give notice to any other persons.

1.9(3) Intervention.

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

b. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the board.

c. A petition for intervention shall be filed with the executive director at the board office. Such a petition is deemed filed when it is received by that office. The board will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BOARD OF MEDICINE	
Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition).	} PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

1.9(4) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The board may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

1.9(5) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the executive director at the board office.

1.9(6) Service and filing of petitions and other papers.

a. *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the executive director at the board office. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the board.

c. Method of service, time of filing, and proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided by 653—25.11(17A).

1.9(7) Consideration. Upon request by petitioner, the board must schedule a brief and informal meeting between the original petitioner, all intervenors, and the board, a member of the board, or a member of the staff of the board, to discuss the questions raised. The board may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the board by any person.

1.9(8) Action on petition.

a. Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the board shall take action on the petition as required by Iowa Code section 17A.9(5).

b. The date of issuance of an order or of a refusal to issue an order is as defined in 653—subrule 25.11(4).

1.9(9) Refusal to issue order.

a. The board shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

(1) The petition does not substantially comply with the required form.

(2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the board to issue an order.

(3) The board does not have jurisdiction over the questions presented in the petition.

(4) The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.

(5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.

(6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.

(7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

(8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.

(9) The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.

(10) The petitioner requests the board to determine whether a statute is unconstitutional on its face.

b. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

c. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

1.9(10) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion. A declaratory order is effective on the date of issuance.

1.9(11) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

1.9(12) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the board, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts

and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the board of medicine. The issuance of a declaratory order constitutes final agency action on the petition.

These rules are intended to implement Iowa Code chapters 17A, 21, 68B, 148, 148E, 252J, 261, and 272C.

653—1.10(68B) Selling of goods or services by members of the board or Iowa physician health committee (IPHC).

1.10(1) *Application of the rule.* The board members and members of the IPHC shall not sell, either directly or indirectly, any goods or services to individuals, associations, or corporations that are subject to the regulatory authority of the department except as authorized by this rule.

1.10(2) *Consent.* Consent shall be given by a majority of the members of the board. Consent shall not be given to an official to sell goods or services to an individual, association, or corporation regulated by the department unless all of the following conditions are met:

a. The official requesting consent does not have authority to determine whether consent should be given.

b. The official's duties or functions are not related to the department's regulatory authority over the individual, association or corporation to whom the goods and services are being sold, or the selling of the good or service does not affect the official's duties or functions.

c. The selling of the good or service does not include acting as an advocate on behalf of the individual, association, or corporation to the department.

d. The selling of the good or service does not result in the official's selling a good or service to the department on behalf of the individual, association, or corporation.

1.10(3) *Authorized sales.* Sales may be authorized under the following conditions:

a. A member of the board or IPHC may sell goods or services to any individual, association, or corporation regulated by any division within the department, other than the board or committee on which that official serves. This consent is granted because the sale of such goods or services does not affect the member's duties or functions on the board or IPHC.

b. A member of the board may sell goods or services to any individual, association, or corporation regulated by the board if those goods or services are routinely provided to the public as part of that person's regular professional practice. This consent is granted because the sale of such goods or services does not affect the board or IPHC member's duties or functions on the board or IPHC, respectively. In the event an individual, association, or corporation regulated by the board, to whom a board or IPHC member sells goods or services is directly involved in any matter pending before the board, including a disciplinary matter, that board or IPHC member shall not participate in any deliberation or decision concerning that matter. In the event a complaint is filed with the board concerning the services provided by the board or IPHC member to a member of the public, that board or IPHC member is otherwise prohibited by law from participating in any discussion or decision by the licensing board in that case.

c. Individual application and approval are not required for the sales authorized by this rule unless there are unique facts surrounding a particular sale which would cause the sale to affect the seller's duties or functions, would give the buyer an advantage in dealing with the board or IPHC, or would otherwise present a conflict of interest.

1.10(4) *Application for consent.* Prior to selling a good or service to an individual, association, or corporation subject to the regulatory authority of the department, an official must obtain prior written consent unless the sale is specifically allowed in subrule 1.10(3). The request for consent must be in writing and signed by the official requesting consent. The application must provide a clear statement of all relevant facts concerning the sale. The application should identify the parties to the sale and the amount of compensation. The application should also explain why the sale should be allowed.

1.10(5) *Limitation of consent.* Consent shall be in writing and shall be valid only for the activities and the time period specifically described in the consent. Consent can be revoked at any time by a majority vote of the members of the board upon written notice to the board. A consent provided under this chapter does not constitute authorization for any activity which is a conflict of interest under common

law or which would violate any other statute or rule. It is the responsibility of the official requesting consent to ensure compliance with all other applicable laws and rules.

This rule is intended to implement Iowa Code section 68B.4.

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CHAPTER 3 WAIVERS

653—3.1(17A,147,148) Definition. For purposes of this chapter, a “waiver” means an action by the board which suspends, in whole or in part, the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—3.2(17A,147,148) Scope of chapter. This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the board in situations where no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

653—3.3(17A,147,148) Applicability of chapter. The board may grant a waiver from a rule only if the board has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The board may not waive requirements created or duties imposed by statute.

653—3.4(17A,147,148) Criteria for waiver. In response to a petition completed pursuant to rule 653—3.6(17A,147,148), the board may, in its sole discretion, issue an order waiving, in whole or in part, the requirements of a rule if the board finds, based on clear and convincing evidence, all of the following:

1. The application of the rule would impose an undue hardship on the person for whom the waiver is requested;
2. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;
3. The provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and
4. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—3.5(17A,147,148) Filing of petition. A petition for a waiver must be submitted in writing to the board, as follows:

3.5(1) License application. If the petition relates to a license application, the petition shall be made in accordance with the filing requirements for the license in question.

3.5(2) Contested cases. If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case.

3.5(3) Other. If the petition does not relate to a license application or a pending contested case, the petition may be submitted to the board’s executive director.

3.5(4) File petition. A petition is deemed filed when it is received in the board office. A petition should be sent to the Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, Iowa 50309-4686. The petition must conform to the form specified in rule 653—3.17(17A,147,148).

653—3.6(17A,147,148) Content of petition. A petition for waiver shall include the following information where applicable and known to the requester:

1. The name, address, and telephone number of the person or entity for whom a waiver is being requested, and the case number of or other reference to any related contested case; and the name, address, and telephone number of the petitioner’s legal representative, if any.
2. A description and citation of the specific rule from which a waiver is requested.
3. The specific waiver requested, including the precise scope and duration.

4. The relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in rule 653—3.4(17A,147,148). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify a waiver.

5. A history of any prior contacts between the board and the petitioner relating to the regulated activity or license affected by the proposed waiver, including a description of each affected license held by the requester, any formal charges filed, notices of violation, contested case hearings, or investigations relating to the regulated activity or license within the past five years.

6. Any information known to the requester regarding the board's action in similar cases.

7. The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the grant of a waiver.

8. The name, address, and telephone number of any person or entity who would be adversely affected by the grant of a petition.

9. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Signed releases of information authorizing persons with knowledge regarding the request to furnish the board with information relevant to the waiver.

653—3.7(17A,147,148) Additional information. Prior to issuing an order granting or denying a waiver, the board may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the board may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the board's executive director, a committee of the board, or a quorum of the board.

653—3.8(17A,147,148) Notice. The board shall acknowledge a petition upon receipt. The board shall ensure that all persons to whom notice is required by any provision of law, including the petitioner, receive notice within 30 days of the receipt of the petition, that the petition is pending and a concise summary of its contents. In addition, the board may give notice to other persons. To accomplish this notice provision, the board may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law, and provide a written statement to the board attesting that notice has been provided.

653—3.9(17A,147,148) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case, and shall otherwise apply to agency proceedings for a waiver only when the board so provides by rule or order or is required to do so by statute.

653—3.10(17A,147,148) Ruling. An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

3.10(1) Board discretion. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the board, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the board based on the unique, individual circumstances set out in the petition.

3.10(2) Burden of persuasion. The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the board should exercise its discretion to grant a waiver from a board rule.

3.10(3) Narrowly tailored. A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

3.10(4) *Administrative deadlines.* When the rule from which a waiver is sought establishes administrative deadlines, the board shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

3.10(5) *Conditions.* The board may place on a waiver any condition that the board finds desirable to protect the public health, safety, and welfare.

3.10(6) *Time period of waiver.* A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the board, a waiver may be renewed if the board finds that grounds for a waiver continue to exist.

3.10(7) *Time for ruling.* The board shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the board shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

3.10(8) *When deemed denied.* Failure of the board to grant or deny a petition within the required time period shall be deemed a denial of that petition by the board. However, the board shall remain responsible for issuing an order denying a waiver.

3.10(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law.

653—3.11(17A,147,148) Public availability. All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the board is authorized or required to keep confidential. The board may accordingly redact confidential information from petitions or orders prior to public inspection.

653—3.12(17A,147,148) Summary reports. Semiannually, the board shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the board's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

653—3.13(17A,147,148) Cancellation of a waiver. A waiver issued by the board pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the board issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or
2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
3. The subject of the waiver order has failed to comply with all conditions contained in the order.

653—3.14(17A,147,148) Violations. Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

653—3.15(17A,147,148) Defense. After the board issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein only for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

653—3.16(17A,147,148) Judicial review. Judicial review of a board’s decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.

653—3.17(17A,147,148) Sample petition for waiver. A petition for waiver filed in accordance with this chapter must meet the requirements specified herein and must substantially conform to the following form:

BEFORE THE BOARD OF MEDICINE

Petition by (name of petitioner)
for the waiver of (insert rule citation)
relating to (insert the subject matter).

}

PETITION FOR
WAIVER

1. Provide the name, address, and telephone number of the petitioner (person asking for a waiver). Also, the name, address, and telephone number of the petitioner’s legal representative, if applicable, and a statement indicating the person to whom communications concerning the petition should be directed.

2. Describe and cite the specific rule from which a waiver is requested.

3. Describe the specific waiver requested, including the precise scope and time period for which the waiver will extend.

4. Explain the relevant facts and reasons that the petitioner believes justify a waiver. Include in your answer all of the following:

a. Why applying the rule would result in undue hardship to the petitioner;

b. Why waiving the rule would not prejudice the substantial legal rights of any person;

c. Whether the provisions of the rule subject to the waiver are specifically mandated by statute or another provision of law; and

d. How substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

5. Provide a history of any prior contacts between the board and petitioner relating to the regulated activity or license that would be affected by the waiver. Include a description of each affected license held by the petitioner, any formal charges filed, any notices of violation, any contested case hearings held, or any investigations related to the regulated activity, license, registration, certification, or permit.

6. Provide information known to the petitioner regarding the board’s action in similar cases.

7. Provide the name, address, and telephone number of any public agency or political subdivision that also regulates the activity in question, or that might be affected by the grant of the petition.

8. Provide the name, address, and telephone number of any person or entity that would be adversely affected by the grant of the waiver.

9. Provide the name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Provide signed releases of information authorizing persons with knowledge regarding the request to furnish the board with information relevant to the waiver.

I hereby attest to the accuracy and truthfulness of the above information.

Petitioner’s signature

Date

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapters 17A, 147, and 148.

[Filed 12/1/00, Notice 10/18/00—published 12/27/00, effective 1/31/01]

[Filed 9/18/08, Notice 8/13/08—published 10/8/08, effective 11/12/08]

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CHAPTER 8

FEES

[Prior to 5/30/01, see 653—Chapter 11]

653—8.1(147,148,272C) Definitions.

“Board” means the Iowa board of medicine.

“Online transaction fee” means a fee of \$7 assessed by the board for completing an online purchase.

The online transaction fee is in addition to the actual service provided.

[ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.2(147,148,272C) Application and licensure fees for acupuncturists.

8.2(1) Licensure provisions for acupuncturists. For licensure provisions for acupuncturists, see 653—Chapter 17, “Licensure of Acupuncturists.”

8.2(2) Fees for acupuncturists. The following fees apply to licensure for acupuncturists.

- a. Initial application fee for licensure as an acupuncturist, \$300.
- b. Reactivation of application for licensure, \$100.
- c. Renewal fee for licensure as an acupuncturist, \$300.
- d. Upon written request and payment of the designated fee, the board shall provide the following information about the status of an acupuncturist’s license or acupuncturist’s past registration:
 - (1) Certified statement that verifies the status of licensure or past registration in Iowa that requires the board seal or a letter of good standing, \$25.
 - (2) Verification of the status of licensure or past registration in Iowa that does not require a certified statement or letter, \$20.

e. Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, \$45.

f. Fee for reinstatement of an acupuncture license, \$400.

g. Penalty for failure to renew before expiration, \$50.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 3464C, IAB 11/22/17, effective 12/27/17; ARC 4246C, IAB 1/16/19, effective 2/20/19]

653—8.3(147,148,272C) Interstate medical licensure compact (IMLC). Provisions for the interstate medical licensure compact are located in 653—Chapter 9, “Permanent and Administrative Medicine Physician Licensure.” The following fees shall apply to the compact.

8.3(1) Service fee for an application for an IMLC letter of qualification. The service fee, described in Chapter 3 of the rules of the interstate medical licensure compact commission, is paid directly to the interstate medical licensure compact commission. The interstate commission retains a portion of this service fee and remits a portion of this service fee to the board. The service fee paid to the interstate commission includes the \$45 fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

8.3(2) Licensure fee for an Iowa license issued through the IMLC. The licensure fee is paid directly to the interstate medical licensure compact commission. An applicant shall pay a licensure fee of \$450 plus a service fee retained by the interstate commission.

8.3(3) Licensure fee for renewal of active Iowa license issued through the IMLC. The licensure fee is paid directly to the interstate medical licensure compact commission. The licensee shall pay the licensure fee described in 8.4(1)“c”(1) plus a service fee retained by the interstate commission. If the license is not renewed prior to expiration, the licensee will incur a penalty as described in 8.4(1)“d.”

[ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.4(147,148,272C) Application and licensure fees to practice medicine and surgery or osteopathic medicine and surgery or administrative medicine.

8.4(1) Fees for permanent licensure. For provisions for permanent licensure, see 653—Chapter 9, “Permanent and Administrative Medicine Physician Licensure.” The following fees shall apply to permanent licensure.

a. Initial licensure, \$450 plus the \$45 fee for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

b. Reactivation of application for licensure, \$150.

c. Renewal of an active license to practice.

(1) \$550 if renewal is made via paper application or \$450 if renewal is made via online application, per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

(2) There is no renewal fee due for a physician who was on active duty in the U.S. armed forces, reserves or national guard during the renewal period. “Active duty” means full-time training or active service in the U.S. armed forces, reserves or national guard. A physician who fails to renew before the expiration of the license shall be charged a penalty fee as set forth in 8.4(1) “*d.*”

d. Penalty for failure to renew before expiration, \$100 per calendar month after the expiration date of the license up to \$200. For example, if the license expired on January 1, a penalty of \$100 shall be charged for January and an additional \$100, or a total of \$200, shall be charged for renewal in February.

e. There is no fee for placing a license on inactive status or allowing a license to become inactive.

f. Reinstatement of a license to practice one year or more after becoming inactive, \$500 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

g. Reinstatement of a license within one year of becoming inactive, \$550 except when the license in the most recent license period had been granted for less than 24 months. In that case, the reinstatement fee is prorated according to the date of issuance and the physician’s month and year of birth.

8.4(2) Fees for resident physician licensure. For provisions for resident physician licensure, see 653—Chapter 10, “Resident, Special and Temporary Physician Licensure.” The following fees apply to resident physician licensure.

a. Application for a resident physician license, \$100 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Extension of a resident physician license, \$25.

c. Late fee for extension of a resident physician license, \$50, to be paid in addition to the extension fee.

8.4(3) Fees for special physician licensure. For provisions for special physician licensure, see 653—Chapter 10, “Resident, Special and Temporary Physician Licensure.” The following fees apply to special physician licensure.

a. Application for a special physician license, \$300 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a special physician license, \$200.

8.4(4) Fees for temporary physician licensure. For provisions for temporary physician licensure, see 653—Chapter 10, “Resident, Special and Temporary Physician Licensure.” The following fees apply to temporary physician licensure.

a. Application for a temporary physician license, \$100 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a temporary physician license, \$50.

8.4(5) Fee for photocopy of a licensure application. Fee for a photocopy of a licensure application is \$20.

8.4(6) Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, \$45.

[ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.5(147,148,272C) Fees for verification of physician licensure and certification of examination scores.

8.5(1) Verification fees.

a. Physicians shall use VeriDoc to secure a certified statement that verifies Iowa licensure status for any state medical board that accepts VeriDoc. VeriDoc is accessible at www.veridoc.org. The fee for this service is \$30.

b. A physician who needs a certified statement that verifies Iowa licensure status for a state medical board that does not accept verification from VeriDoc shall make a written request for a certified statement with payment of a \$30 verification fee to the Iowa Board of Medicine. The Iowa board shall provide a certified statement that verifies Iowa licensure status to the nonaccepting state medical board.

c. The fee for verification of Iowa licensure status that does not require a certified statement or letter is \$15.

d. The board shall provide an automated telephone or electronic verification service whereby users can input the licensee's license number to learn the licensee's current licensure status. There is no fee for this service.

The board shall provide a license number for an individual caller to use in the automated telephone or electronic verification service. Businesses that utilize verifications will be required to utilize the automated telephone or electronic verification service or the alternative outlined in 8.5(1) "c."

8.5(2) Fees for certification of physician examination scores. Upon request and payment of the designated fee, the board may provide certification of scores of an examination given by the board in Iowa as permitted under Iowa Code section 147.21 and 653—paragraph 2.13(2) "f." The scores available from the board are those from examinees who took the state-constructed examination.

a. Certified statement of grades attained by examination, \$45.

b. Certified statement of grades attained by examination including examination history or additional documentation, \$55.

[ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.6(147,148,272C) Public records.

8.6(1) Public records available at no cost. The following records are available at no cost to the public:

a. Public action taken by the board against a licensee may be found under the licensee's name on the board's website, www.medicalboard.iowa.gov, under "Find A Physician." Public actions are posted on the board's website within approximately one week after the board has taken action.

b. Electronic files of press releases, statements of charges, final orders and consent agreements from each board meeting are available within approximately one week after the board has taken action. These files are available on the board's website, www.medicalboard.iowa.gov.

8.6(2) Purchase of public records. Public records are available according to 653—Chapter 2, "Public Records and Fair Information Practices." Payment made to the Iowa Board of Medicine shall be received in the board office prior to the release of the records.

a. Printed copies of public records shall be calculated at \$.25 per page plus labor. The board may charge a \$16 per hour fee for labor in excess of one-quarter hour for searching and copying documents or retrieving and copying information stored electronically. No additional fee shall be charged for delivery of the records by mail, fax, or email. Fax is an option if the requested records are fewer than 30 pages. The board office shall not require payment when the fees for the request would be less than \$5 total.

b. Electronic copies of public records delivered by email shall be provided at no charge per page. The board may charge a \$16 per hour fee for labor in excess of one-quarter hour for searching and copying documents or retrieving and copying information stored electronically.

[ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—8.7(147,148,272C) Licensee data list. A data list of all physicians and acupuncturists includes the following information about each licensee: full name, year of birth, work address and telephone number (or other contact information on file if licensee's work address and telephone number are not available), Iowa county (if applicable), medical school (if applicable), year of graduation from medical school (if applicable), two medical specialties (if available), license issue date, license expiration date, license number, license type, license status, and an indicator of whether the board has taken any public action on the license. There is no fee for an electronic file of this list. A printed copy of the data list is

available at the board's office at fees described in rule 653—8.6(147,148,272C). Payment made to the Iowa Board of Medicine shall be received in the board office prior to the release of a printed copy of the list.

[ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.8(147,148,272C) Returned checks. The board shall charge a fee of \$25 for a check returned for any reason. If a license had been issued by the board office based on a check that is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification of the returned check by certified mail, the licensee shall be subject to disciplinary action for noncompliance with board rules.

653—8.9(147,148,272C) Copies of the laws and rules. Electronic copies of laws and rules pertaining to the practice of medicine or acupuncture are available at www.legis.iowa.gov at no cost. Printed copies of these laws and rules are available at the board's office at fees described in rule 653—8.6(147,148,272C). [ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 3464C, IAB 11/22/17, effective 12/27/17]

653—8.10(147,148,272C) Refunds. Application and licensure fees shall be collected by the board and shall not be refunded except by board action in unusual instances, e.g., documented illness or death of the applicant. The board shall consider the cost of the work completed on the application and the cost of the work to grant a refund in determining the amount of refund to be granted.

653—8.11(17A,147,148,272C) Waiver prohibited. Licensure and examination fees in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law. [ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—8.12(8,147,148,272C) Request for reports. The board may request a report from the National Practitioner Data Bank regarding an applicant or licensee. The cost of obtaining the report is included within the fee for initial licensure or licensure reinstatement or renewal. [ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—8.13(8,147,148,272C) Monitoring fee. The board may require payment of up to \$300 per quarter to cover the board's expenses to monitor a licensee's compliance with a settlement agreement or final decision and order. [ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—8.14(147,148,272C) Application and licensure fees for genetic counselors.

8.14(1) Licensure provisions for genetic counselors. Licensure provisions for genetic counselors can be found at 653—Chapter 20, "Licensure of Genetic Counselors."

8.14(2) Fees for genetic counselors. The following fees apply to licensure and provisional licensure for genetic counselors.

- a. Initial application fee for licensure, \$200.
- b. Reactivation of application for licensure, \$100.
- c. Renewal of an active license, \$200.
- d. Penalty for failure to renew before expiration, \$50.
- e. Upon written request and payment of the designated fee, the board shall provide the following information about the status of a genetic counselor's license:
 - (1) Certified statement that verifies the status of licensure in Iowa that requires the board seal or a letter of good standing, \$25.
 - (2) Verification of the status of licensure in Iowa that does not require a certified statement or letter, \$20.
- f. Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, \$45.

g. Fee for reinstatement of a license, \$300.
[ARC 4246C, IAB 1/16/19, effective 2/20/19]

These rules are intended to implement Iowa Code sections 147.11, 147.80, 148.3, 148.5, 148.10, and 148.11.

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CHAPTER 9
PERMANENT AND ADMINISTRATIVE MEDICINE PHYSICIAN LICENSURE

[Prior to 5/30/01, see 653—Chapter 11]

653—9.1(147,148) Definitions.

“*ABMS*” means the American Board of Medical Specialties, which is an umbrella organization for at least 24 medical specialty boards in the United States that assists the specialty boards in developing and implementing educational and professional standards to evaluate and certify physician specialists in the United States. The board recognizes specialty board certification by ABMS.

“*ACGME*” means the Accreditation Council for Graduate Medical Education, an accreditation body that is responsible for accreditation of post-medical school training programs in medicine and surgery in the United States of America. The board approves resident training programs accredited by ACGME.

“*Administrative medicine*” means administration or management utilizing the medical and clinical knowledge, skill, and judgment of a licensed physician and capable of affecting the health and safety of the public or any person. A physician with an administrative medicine license may advise organizations, both public and private, on health care matters; authorize and deny financial payments for care; organize and direct research programs; review care provided for quality; and perform other similar duties that do not require direct patient care. “Administrative medicine” does not include the authority to practice clinical medicine; examine, care for or treat patients; prescribe medications, including controlled substances; or delegate medical acts or prescriptive authority to others.

“*Administrative medicine license*” means a license issued by the board pursuant to 653—9.20(147,148).

“*AMA*” means the American Medical Association, a professional organization of physicians and surgeons.

“*Any jurisdiction*” means any state, the District of Columbia or territory of the United States of America or any other nation.

“*Any United States jurisdiction*” means any state, the District of Columbia or territory of the United States of America.

“*AOA*” means the American Osteopathic Association, which is the representative organization for osteopathic physicians (D.O.s) in the United States. The board approves osteopathic medical education programs with AOA accreditation; the board approves AOA-accredited resident training programs in osteopathic medicine and surgery at hospitals for graduates of accredited osteopathic medical schools. The board recognizes specialty board certification by AOA. The board recognizes continuing medical education accredited by the Council on Continuing Medical Education of AOA.

“*Applicant*” means a person who seeks authorization to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine in this state by making application to the board, or a physician who seeks licensure through the IMLC.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of public health or a training program offered by a hospital, a professional organization for physicians, or the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Board*” means Iowa board of medicine.

“*Board-approved resident training program*” means a hospital-affiliated graduate medical education program accredited by ACGME, AOA, RCPSA, or CFPC at the time the applicant is enrolled in the program.

“*Candidate*” means a person who applies to sit for an examination administered by the board or its designated testing service.

“*Category 1 credit*” means any formal education program which is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and

is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*CFPC*” means the College of Family Physicians of Canada, an organization that accredits graduate medical education in family practice in Canada.

“*COCA*” means the Commission on Osteopathic College Accreditation.

“*COMLEX*” means the Comprehensive Osteopathic Medical Licensing Examination that is recognized by the board as the licensure examination that replaced the NBOME examination for graduates of osteopathic medical schools or colleges.

“*Committee*” means the licensure committee of the board.

“*COMVEX-USA*” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America. The National Board of Osteopathic Medical Examiners prepares the examination and determines its passing score. A licensing authority in any jurisdiction administers the examination. COMVEX-USA is the current evaluative instrument offered to osteopathic physicians who need to demonstrate current osteopathic medical knowledge.

“*Conviction*” for the purposes of licensure through the IMLC means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of conviction of a criminal offense by the court shall be considered final for the purposes of disciplinary action by a member board of the IMLC.

“*Core credentials*” means those documents that demonstrate the applicant’s identity, medical training and practice history. “Core credentials” includes but is not limited to: medical school verification, medical school diploma, examination history, current ECFMG status report, fifth pathway certificate, and postgraduate training verification.

“*Criminal offense*” for the purposes of licensure through the IMLC means a felony, gross misdemeanor, or crime of moral turpitude.

“*Current, active status*” means a license that is in effect and grants the privilege of practicing administrative medicine, medicine and surgery or osteopathic medicine and surgery, as applicable.

“*ECFMG*” means the Educational Commission for Foreign Medical Graduates, an organization that assesses the readiness of foreign medical school graduates to enter ACGME-approved graduate medical education programs in the United States.

“*Expedited license*” means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the IMLC.

“*FCVS*” means the Federation Credentials Verification Service, a service under the Federation of State Medical Boards that verifies and stores core credentials for retrieval whenever needed.

“*FLEX*” means the Federation Licensing Examination, a licensure examination used in the past that was approved by the board for graduates with a medical degree.

“*Foreign medical school,*” also known as an “international medical school,” means a medical school that is located outside of any United States jurisdiction or Canada.

“*FSMB*” means the Federation of State Medical Boards, the organization of medical boards of the United States of America.

“*IMLC*” means the Interstate Medical Licensure Compact enacted in Iowa Code chapter 147B.

“*Inactive license*” means any license that is not in current, active status. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice under an inactive Iowa license until the inactive license is reinstated to active status.

“*Incidentally called into this state in consultation with a physician and surgeon licensed in this state*” as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as

to the care that should be provided, but the consulting physician may not personally perform procedures, write orders, or prescribe for the patient.

4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.

5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient's care.

"Initial license" means the first permanent or administrative medicine license granted to a qualified individual.

"International medical school," also known as a "foreign medical school," means a medical school that is located outside of any United States jurisdiction or Canada.

"Interstate commission" means the interstate commission created pursuant to Iowa Code chapter 147B.

"LCME" means Liaison Committee on Medical Education, an organization that accredits educational institutions granting degrees in medicine and surgery. The board approves programs that are accredited by LCME.

"LMCC" means enrollment in the Canadian Medical Register as Licentiate of Medical Council of Canada with a certificate of registration as proof. LMCC requires passing both parts of the Medical Council of Canada Qualifying Examination.

"MCCEE" means the Medical Council of Canada Evaluating Examination, an examination administered in Canada to physicians who graduated from a medical school outside of the United States or Canada.

"Medical degree" means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from a foreign medical school.

"National Practitioner Data Bank" is a national data bank of disciplinary actions taken against health professionals, including physicians.

"NBME" means the National Board of Medical Examiners, an organization that prepares and administers qualifying examinations, either independently or jointly with other organizations.

"NBOME" means the National Board of Osteopathic Medical Examiners, an organization that prepares and administers qualifying examinations for osteopathic physicians.

"Observer" means a person who is not enrolled in an LCME- or COCA-accredited medical school or osteopathic medical school, who observes care to patients in Iowa for a defined period of time and for a noncredit experience, and who is supervised and accompanied by an Iowa-licensed physician as defined in 9.2(3). An observer shall not provide or direct hands-on patient care, regardless of the observer's level of training or supervision. The supervising physician may authorize an observer to read a chart, observe a patient interview or examination, or witness procedures, including surgery. An observer shall not chart; touch a patient as part of an examination; conduct an interview; order, prescribe or administer medications; make decisions that affect patient care; direct others in providing patient care; or conduct procedures, including surgery. Any of these activities requires licensure to practice in Iowa. An unlicensed physician observer or a medical student observer who is not enrolled in an LCME- or COCA-accredited medical school may touch a patient to verify a physical finding in the immediate presence of a physician but shall not conduct a more inclusive physical examination.

An unlicensed physician observer may:

1. Participate in discussions regarding the care of individual patients, including offering suggestions about diagnosis or treatment, provided the unlicensed physician observer does not direct the care; and

2. Elicit information from a patient provided the unlicensed physician observer does not actually perform a physical examination or otherwise touch the patient.

"Permanent licensure" means licensure granted after review of the application and core credentials to determine that the individual is qualified to enter into clinical practice. The individual may only practice when the license is in current, active status.

"Practice" means the practice of medicine and surgery or osteopathic medicine and surgery.

"Primary source verification" means:

1. Verification of the authenticity of documents with the original source that issued the document.
2. Original source verification by another jurisdiction's physician licensing organization.
3. Original source verification by the FSMB's Federation Credentials Verification Service.

"RCPSC" means the Royal College of Physicians and Surgeons of Canada, an organization that accredits graduate medical education in Canada.

"Reinstatement" means the process for returning an inactive license to current, active status.

"Relinquishment" means that a person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine is deemed abandoned if the person fails to renew or reinstate the license within five years after its expiration. A license that has been relinquished is no longer valid or renewable. Relinquishment is not disciplinary in nature.

"Resident physician" means a physician enrolled in an internship, residency or fellowship.

"Resident training program" means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

"Service charge" means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

"SPEX" means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

"Terminated license" means a nondisciplinary process by which an Iowa license issued through the Interstate Medical Licensure Compact is no longer eligible for renewal. A compact license is terminated when a licensee no longer meets the IMLC qualifications. A terminated IMLC license may not be reinstated.

"Training for chronic pain management" means required training on chronic pain management identified in 653—Chapter 11.

"Training for end-of-life care" means required training on end-of-life care identified in 653—Chapter 11.

"Training for identifying and reporting abuse" means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively, as specified in 653—Chapter 11. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69; the full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

"Uniform application for physician state licensure" means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure. The Federation of State Medical Boards created and maintains the application. This application is used for all license types issued by the Iowa board of medicine.

"USMLE" means the United States Medical Licensing Examination.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2346C, IAB 1/6/16, effective 2/10/16; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.2(147,148) General licensure provisions.

9.2(1) Licensure required. Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in subrule 9.2(2). Provisions for permanent physician licensure, licensure through the IMLC, and administrative medicine licensure are found in this chapter; provisions for resident, special and temporary physician licensure are found in 653—Chapter 10.

9.2(2) Licensure not required. The following persons are not required to obtain a license to practice in Iowa:

- a. Those persons described in Iowa Code sections 148.2(1) to 148.2(5).

(1) A medical student or osteopathic medical student in an international medical school may not take on the role of a medical student in the patient care setting unless the student is enrolled in the University of Iowa's Carver College of Medicine or in Des Moines University's College of Osteopathic

Medicine; however, an international medical student not enrolled at either of these institutions may be an observer as defined in rule 653—9.1(147,148).

(2) A graduate of an international medical school shall not practice medicine without an Iowa medical license; however, the graduate may be an observer as defined in rule 653—9.1(147,148).

b. Those persons who are incidentally called into this state in consultation with a physician or surgeon licensed in this state as described in Iowa Code section 148.2(5) and as defined in rule 653—9.1(147,148).

c. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa on a temporary basis to aid disaster victims at the time of a disaster in accordance with Iowa Code section 29C.6.

d. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come to Iowa to participate in further medical education may participate in patient care under the request and supervision of the patient's Iowa-licensed physician in charge of the education. The Iowa-licensed physician shall retain the primary responsibility for management of the patient's care.

e. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa to serve as expert witnesses as long as they do not provide treatment.

f. Physicians and surgeons from out of state who hold a current, active license in good standing in another United States jurisdiction and who accompany one or more individuals into Iowa for the purpose of providing medical care to these individuals on a short-term basis, e.g., a team physician for an out-of-state college football team that comes into Iowa for a game.

g. Physicians and surgeons who come to Iowa to observe patient care and who do not provide or direct hands-on patient care.

h. Visiting resident physicians who come to Iowa to practice as part of their resident training program if under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (see rule 653—10.5(147,148)).

9.2(3) *Supervision of an observer.* An Iowa-licensed physician who supervises an observer shall accompany the observer and solicit consent from each patient, where feasible, for the observation. The physician shall inform the patient of the observer's background, e.g., high school student considering a medical career, a medical graduate who is working on licensure. The supervising physician shall ensure that the observer remains within the scope of an observer as defined in rule 653—9.1(147,148).

[ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.3(147,148) Eligibility for licensure.

9.3(1) *Requirements.* To be eligible for permanent or administrative medicine licensure, an applicant shall meet all of the following requirements:

a. Fulfill the application requirements specified in rule 653—9.4(147,148).
b. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board shall be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for the educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant shall meet one of the following requirements:

1. Hold a valid certificate issued by ECFMG;
2. Pass the MCCEE;
3. Have successfully completed a fifth pathway program established in accordance with AMA criteria;
4. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and have successfully completed three years of resident training in a program approved by the board; and have submitted evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction; or

5. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and hold board certification by a specialty board approved by ABMS or AOA; and submit evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction.

c. Have successfully completed one year of resident training in a hospital-affiliated program approved by the board at the time the applicant was enrolled in the program. An applicant who is a graduate of an international medical school shall have successfully completed 24 months of such training.

(1) For those required to have 12 months of training, the program shall have been 12 months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board. For those required to have 24 months of training, the program shall have been 24 continuous months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board.

(2) Resident training approved by the board shall be accredited by an accrediting agency recognized by the board for the purpose of accrediting resident training programs.

(3) The board approves resident training programs accredited by:

1. ACGME;
2. AOA;
3. RCPSC; and
4. CFPC.

(4) The board shall accept each 12 months of practice as a special licensee as equivalent to one year of resident training in a hospital-affiliated program approved by the board.

(5) The board may accept a current, active ABMS or AOA board certification obtained through an alternate pathway as equivalent to resident training in a hospital-affiliated program approved by the board. The alternate pathway must be a minimum of 24 months completed at an institution with a program approved by the board as specified in subparagraph 9.3(1) “c”(3).

d. Pass one of the licensure examinations or combinations as prescribed in rule 653—9.7(147,148).

9.3(2) Exceptions to the eligibility requirements.

a. A military service applicant or a veteran may apply for credit for verified military education, training, or service toward any experience or educational requirement for permanent licensure under this subrule or may be eligible for permanent licensure through reciprocity as specified in 653—Chapter 18.

b. A physician who holds a valid Letter of Qualification asserting eligibility for licensure through the IMLC is eligible for a permanent Iowa medical license.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.4(147,148) Licensure application.

9.4(1) Requirements. To apply for licensure, an applicant shall:

a. Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—paragraph 8.4(1) “a”; and

b. Complete and submit forms provided by the board, including required core credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth

of all information provided by the applicant, which has been signed by the applicant in the physical presence (in the same room) of a notary public.

c. Pass one of the examinations as prescribed in rule 653—9.7(147,148) and authorize the testing authority to verify scores.

9.4(2) Application. The application shall require the following information:

a. Full legal name, date and place of birth, home address, mailing address, principal business address, and personal e-mail address regularly used by the applicant or licensee for correspondence with the board.

b. A photograph of the applicant suitable for positive identification.

c. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

d. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

e. A certified statement of scores on any licensure examination required in rule 653—9.7(147,148) that the applicant has taken in any jurisdiction. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

f. A photocopy of the applicant's medical degree issued by an educational institution.

(1) A complete translation of any diploma not written in English shall be submitted. An official transcript, written in English and received directly from the school, showing graduation from medical school is a suitable alternative.

(2) An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

(3) If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

g. A sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

h. An official transcript, or its equivalent, received directly from the school for every medical school attended if requested by the board. A complete translation of any transcript not written in English shall be submitted if requested by the board. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

i. If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a current ECFMG status report or evidence of successful completion of a fifth pathway program in accordance with criteria established by AMA. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

j. Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“c.” An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

k. Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

l. A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

m. A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care. Copies of evaluations, verification of medical condition from treating physicians, or other documentation may be requested if needed during the review process.

n. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

o. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending. Copies of the legal documents may be requested if needed during the review process.

p. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.5(147,148) Licensure by endorsement. Rescinded ARC 3587C, IAB 1/17/18, effective 2/21/18.

653—9.6(147,148) Licensure by expedited endorsement. Rescinded ARC 3587C, IAB 1/17/18, effective 2/21/18.

653—9.7(147,148) Licensure examinations.

9.7(1) USMLE.

a. The USMLE is a joint program of FSMB and the NBME. The USMLE is a multipart examination consisting of Step 1, Step 2, and Step 3. Steps 1 and 2 are administered by NBME and ECFMG. The board contracts with FSMB for the administration of Step 3. USMLE Steps 1 and 2 were implemented in 1992; Step 3 was implemented in 1994.

b. Since 1999, Step 3 is a computerized examination offered at testing centers in the Des Moines area and other locations around Iowa and the United States.

c. Applications are available at Department of Examination Services, FSMB, 400 Fuller Wiser Road, Suite 300, Euless, Texas 76039, or www.fsmb.org.

d. Candidates who meet the following requirements are eligible to take USMLE Step 3:

(1) Submit a completed application form and pay the required examination fee as specified in rule 653—8.3(147,148,272C).

(2) Document successful completion of USMLE Steps 1 and 2 in accordance with the requirements of NBME. Graduates of a foreign medical school shall meet the requirements of ECFMG.

(3) Document holding a medical degree from a board-approved educational institution. If a candidate holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the candidate shall meet the requirements specified in subparagraph 9.3(1)“b”(3).

(4) Document successful completion of a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Step 3 or enrollment in a resident training program approved by the board at the time of the application for Step 3.

e. The following conditions shall apply to applicants for licensure in Iowa who utilize USMLE as the licensure examination.

(1) Passing Steps 1, 2, and 3 is required within a ten-year period beginning with the date of passing either Step 1 or Step 2, whichever occurred first. If the applicant did not pass Steps 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint M.D./Ph.D. or D.O./Ph.D. program.

(2) Step 3 may be taken and passed only after Steps 1 and 2 are passed.

(3) A score of 75 or better on each step shall constitute a passing score on that step.

(4) Each USMLE step must be passed individually, and individual step scores shall not be averaged to compute an overall score.

(5) A failure of any USMLE step, regardless of the jurisdiction for which it was taken, shall be considered a failure of that step for the purposes of Iowa licensure.

(6) Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Step 1 or six attempts on Step 2 CK and Step 2 CS combined or three attempts on Step 3.

f. Any candidate deemed eligible to sit for USMLE Step 3 is required to adhere to the examination procedures and protocol established by FSMB and NBME in the following publications: USMLE Test Administration Standards and Policies and Procedures Regarding Indeterminate Scores and Irregular Behavior, FSMB, 400 Fuller Wiser Road, Suite 300, Eules, Texas 76039.

9.7(2) NBME.

a. NBME Part Examinations (Parts I, II, and III) were first administered in 1916. The last regular administration of Part I occurred in 1991, Part II in April 1992, and Part III in May 1994.

b. Successful completion of NBME Parts I, II, and III was a requirement for NBME certification.

c. A score of 75 or better on each part shall constitute a passing score on that part.

9.7(3) FLEX.

a. From 1968 to 1985, (Old) FLEX was a three-day examination. Day 1 covered basic science; Day 2 covered clinical science; and Day 3 covered clinical competency. Applicants who took Old FLEX shall provide evidence of successful achievement of at least two of the following:

(1) Certification under seal that the applicant passed FLEX with a FLEX-weighted average of 75 percent or better, as determined by the state medical licensing authority, in no more than two sittings.

(2) Verification under seal of medical licensure in the state that administered the examination.

(3) Evidence of current certification by an American specialty board approved or recognized by the Council of Medical Education of AMA, ABMS, or AOA.

b. From 1985 to 1994, (New) FLEX replaced the Old FLEX. New FLEX was a three-day nationally standardized examination consisting of two, one and one-half day components referred to as Component I (basic and clinical science principles and mechanisms underlying disease and modes of therapy) and Component II (knowledge and cognitive abilities required of a physician assuming independent responsibility for the general delivery of medical care to patients). The last regular administration of both components of New FLEX occurred in 1993. Two special administrations of New FLEX Component I were offered in 1994 to examinees who passed Component II but not Component I prior to 1994. To be eligible for licensure, the candidate must have passed both components with a FLEX score of 75 or better within a seven-year period beginning with the date of initial examination.

(1) Candidates who took the FLEX for the first time were required to take both components during the initial sitting. A candidate who failed either or both components must have repeated and passed the component failed, though Component II could only be repeated if the candidate had received a passing score of 75 percent or better on Component I.

(2) Eligible candidates were permitted to sit for the initial examination and reapply to the board to repeat a failed component or complete the entire examination two additional times. However, candidates who failed either or both components three times were required to wait one year, during which time the candidate was encouraged to obtain additional training, before being permitted to sit two additional times for either or both components of the FLEX.

9.7(4) Combination examination sequences. To accommodate individuals who had already passed some part of the NBME Parts or FLEX before implementation of the USMLE, the USMLE program recommended and the board approved the following licensing combinations of examinations for licensure only if completed prior to January 1, 2000. These combinations are now only acceptable from an applicant who already holds a license from any United States jurisdiction.

a. FLEX Component I plus USMLE Step 3 with a passing score of 75 or better on each examination;

b. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component II with a passing score of 75 or better on each examination; or

c. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3 with a passing score of 75 or better on each examination.

9.7(5) COMLEX. COMLEX is a three-level examination that replaced the three-part NBOME examination. COMLEX Level 3 was first administered in February 1995; Level 2 was first administered in March 1997; and Level 1 was first administered in June 1998. All three examinations must be successfully completed in sequential order within ten years of the successful completion of COMLEX Level 1. If the applicant did not pass Levels 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint D.O./Ph.D. or M.D./Ph.D. program.

a. A standard score of 400 on Level 1 or Level 2 is required to pass the examination. A standard score of 350 on Level 3 is required to pass the examination.

b. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Level 3 or enrollment in a resident training program approved by the board at the time of the application for Level 3.

c. Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Level 1 or six attempts on Level 2 CE and Level 2 PF combined or three attempts on Level 3.

d. Each COMLEX level must be passed individually, and individual level scores shall not be averaged to compute an overall score.

e. Level 3 may be taken and passed only after Levels 1 and 2 are passed.

f. A failure of any COMLEX level, regardless of the jurisdiction for which it was taken, shall be considered a failure of that level for the purposes of Iowa licensure.

9.7(6) NBOME.

a. NBOME was a three-part examination. All three parts must have been successfully completed in sequential order within seven years of the successful completion of NBOME Part 1.

b. A passing score is required on each part of the examination.

c. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for NBOME Part 3. Candidates shall have completed their resident training by the last day of the month in which the examination was taken.

d. Successful completion of a three-year resident training program is required if the applicant passes the examination after more than six attempts on Part 1 or six attempts on Part 2 or three attempts on Part 3.

e. Each NBOME part must have been passed individually, and individual part scores shall not be averaged to compute an overall score.

f. Part 3 must have been taken and passed only after Parts 1 and 2 were passed.

g. A failure of any NBOME part, regardless of the jurisdiction for which it was taken, shall be considered a failure of that part for the purposes of Iowa licensure.

9.7(7) LMCC.

a. The board accepts toward Iowa licensure a verification of a licentiate's registration with the Medical Council of Canada, based on passing both parts of the Medical Council of Canada Qualifying Examination.

b. The Medical Council of Canada may be contacted at 1021 Thomas Spratt Place, Ottawa, Ontario, Canada K1G 5L5 or (613) 520-2240.

9.7(8) State licensing examinations. The Iowa board of medicine administered a state licensing examination until 1968. Licensing examinations administered by the Iowa board of medicine or another U.S. jurisdiction prior to 1974 are accepted if the examination was passed according to criteria established by that state at the time and led to licensure in that state.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.8(147,148) Permanent licensure application review process. The process below shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve

provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

9.8(1) An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial licensure fee.

9.8(2) After reviewing each application, board staff shall notify the applicant about how to resolve any problems. An applicant shall provide additional information when requested by staff or the board.

9.8(3) If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

9.8(4) If the final review indicates questions or concerns that cannot be remedied by continued communication with the physician, the executive director, director of licensure and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

a. If there is no current concern, staff shall administratively grant the license.

b. If any concern exists, the application shall be referred to the committee.

9.8(5) Staff shall refer to the committee for review matters which include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

9.8(6) If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant the license administratively.

9.8(7) If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

a. Request an investigation;

b. Request that the applicant appear for an interview;

c. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

d. Grant a license;

e. Grant a license under certain terms and conditions or with certain restrictions;

f. Request that the applicant withdraw the licensure application; or

g. Deny a license.

9.8(8) The board shall consider applications and recommendations from the committee and shall:

a. Request further investigation;

b. Require that the applicant appear for an interview;

c. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

d. Grant a license;

e. Grant a license under certain terms and conditions or with certain restrictions;

f. Request that the applicant withdraw the licensure application; or

g. Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.17(147,148). [ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.9(147,148) Licensure application cycle.

9.9(1) Failure to submit application materials. If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status.

9.9(2) Reactivation of the application. To reactivate the application, an applicant shall submit a nonrefundable fee for reactivation of the application as specified in 653—paragraph 8.4(1) "b" within 30 days. If the application is not reactivated within 30 days, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

9.9(3) Period of reactivation. The period for reactivation of application shall extend 90 days from the date the request and fee are received in the board office. During this period, the applicant shall update core credentials and submit the remaining requested materials. If the applicant does not update core credentials or submit all materials during the 90-day period of reactivation, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.10(147,148) Discretionary board actions on licensure applications. As circumstances warrant, the board may determine that any applicant for licensure is subject to the following:

9.10(1) The board may impose limits or restrictions on the practice of any applicant in this state that are equal in force to the limits or restrictions imposed on the applicant by any jurisdiction.

9.10(2) The board may defer final action on an application for licensure if there is an investigation or disciplinary action pending against an applicant in any jurisdiction until such time as the board is satisfied that licensure of the applicant poses no risk to the health and safety of Iowans.

9.10(3) The board is not precluded from taking disciplinary action after licensure is granted related to issues that arose in the licensure application process.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.11(147,148) Issuance of a license.

9.11(1) Issuance. Upon the granting of permanent or administrative medicine licensure, staff shall issue a license to practice that shall expire on the first day of the licensee's birth month.

a. Licenses of persons born in even-numbered years shall expire in an even-numbered year, and licenses of persons born in odd-numbered years shall expire in an odd-numbered year.

b. The license shall not be issued for a period less than two months or greater than two years and two months, in accordance with the licensee's month and year of birth.

c. When a resident physician receives a permanent Iowa license, the resident physician license shall immediately become inactive.

d. When a physician with a special license receives a permanent Iowa license, the special license shall immediately become inactive.

e. When a physician with a permanent Iowa license receives an Iowa administrative medicine license, the permanent Iowa license shall immediately become inactive.

f. A physician with an active permanent Iowa license is ineligible for an Iowa resident license.

9.11(2) Display of license certificate. The license certificate shall be displayed in the licensee's primary location of practice.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.12(147,148) Notification required to change the board's data system.

9.12(1) *Change of contact information.* A licensee shall notify the board of any change in the home address, the address of the place of practice, home or practice telephone number, or personal e-mail address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

9.12(2) *Change of name.* A licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

9.12(3) *Deceased.* A licensee file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate or other reliable information of the licensee's death.

9.12(4) *Practice name.* A licensee shall practice under the licensee's full legal name.
[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.13(147,148) Renewal of a permanent or administrative medicine license.

9.13(1) *Renewal notice.* Staff shall send a renewal notice to each licensee at least 60 days prior to the expiration of the license. The renewal notice may be sent by e-mail or by regular mail at the discretion of staff. If e-mail is used for notification of licensure renewal, the notice shall be sent to the personal e-mail address specified in subrule 9.12(1).

9.13(2) *Licensee obligation.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

9.13(3) *Renewal application requirements.* A licensee seeking renewal shall submit a completed renewal application; information on continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse; and the required fee prior to the expiration date on the current license.

a. Renewal fee.

(1) The fees for renewal made via paper application or via on-line application are specified in 653—subparagraph 8.4(1) "c"(1) and are assessed per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

(2) There is no renewal fee due for a physician who was on active duty in the U.S. armed forces, reserves or national guard during the renewal period. "Active duty" means full-time training or active service in the U.S. armed forces, reserves or national guard.

(3) A physician who fails to renew before the expiration of the license shall be charged a penalty fee as set forth in 653—paragraph 8.4(1) "d."

b. The requirements for continuing education and training on identifying and reporting abuse are found in 653—Chapter 11.

c. The first renewal fee shall be prorated on a monthly basis according to the date of issuance and the physician's month and year of birth, if the initial permanent or administrative medicine license was issued for a period of less than 24 months.

9.13(4) *Issuance of a renewal.* Upon receiving the completed renewal application, staff shall administratively issue a two-year license that expires on the first day of the licensee's birth month. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration.

9.13(5) *Renewal penalties.* If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, the licensee shall be charged a penalty fee as set forth in 653—paragraph 8.4(1) "d."

9.13(6) *Failure to renew.* Failure of the licensee to renew a license within two months following its expiration date shall cause the license to become inactive and invalid. A licensee whose license is invalid or inactive is prohibited from practice until the license is reinstated in accordance with rule 653—9.15(147,148).

a. In order to ensure that the license will not become inactive when a paper renewal form is used, the completed renewal application and appropriate fees must be received in the board office by the fifteenth of the month prior to the month the license becomes inactive. For example, a licensee whose license expires on January 1 has until March 1 to renew the license or the license becomes inactive and invalid. The licensee must submit and the board office must receive the renewal materials prior to or on February 15 to ensure that the license will be renewed prior to becoming inactive and invalid on March 1.

b. In order to ensure that the license will not become inactive when on-line renewal is used, the licensee must complete the on-line renewal prior to midnight of the last day of the month in the month after the expiration date on the license. For example, a licensee whose license expiration date is January 1 must complete the on-line renewal before midnight on the last day of February; the license becomes inactive and invalid at 12:01 a.m. on March 1.

9.13(7) *Display of license.* Renewal licenses shall be displayed along with the license certificate in the primary location of practice.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.14(147,148) Inactive status and reinstatement of a license.

9.14(1) *Definition of inactive status.* An inactive license is any license that is not a current, active license.

a. “Inactive status” may include licenses formerly known as delinquent, lapsed, or retired.

b. A physician with an inactive license may not practice medicine until the license is reinstated to current, active status.

c. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reinstated to current, active status. A licensee who practices under an Iowa license when the license is inactive may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, or other available legal remedies.

9.14(2) *Mechanisms for becoming inactive.* A licensee seeking to become inactive may do so by submitting a written request to the board office or by failing to renew a license by the first day of the third month after the expiration date. For example, a licensee whose license expires on January 1 will be considered inactive if the license is not renewed by March 1.

9.14(3) *Fee.* There is no fee to become inactive.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.15(147,148) Reinstatement of an unrestricted Iowa license.

9.15(1) *Reinstatement within one year of the license’s becoming inactive.* An individual whose license is in inactive status for up to one year and who wishes to reinstate the license shall submit a completed renewal application; the reinstatement fee; documentation of continuing education; and, if applicable, documentation on training on chronic pain management, end-of-life care, and identifying and reporting abuse. All of the information shall be received in the board office within one year of the license’s becoming inactive for the applicant to reinstate under this subrule. For example, a physician whose license became inactive on March 1 has until the last day of the following February to renew under this subrule.

*a. *Fee for reinstatement of an unrestricted Iowa license within one year of the license’s becoming inactive.** The reinstatement fee is specified in 653—paragraph 8.4(1) “g” when the license in the most recent license period had been granted for less than 24 months; in that case, the reinstatement fee is prorated according to the date of issuance and the physician’s month and year of birth.

*b. *Continuing education and training requirements.** The requirements for continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse are found in 653—Chapter 11. Applicants for reinstatement shall provide documentation of having completed:

(1) The number of hours of category 1 credit needed for renewal in the most recent license period. None of the credits obtained in the inactive period may be carried over to a future license period; and

(2) Training on chronic pain management, end-of-life care, and identifying and reporting abuse, if applicable, within the previous five years.

c. Issuance of a reinstated license. Upon receiving the completed application, staff shall administratively issue a license that expires on the renewal date that would have been in effect if the licensee had renewed the license before the license expired.

d. Reinstatement application process. The applicant who fails to submit all reinstatement information required within 365 days of the license's becoming inactive shall be required to meet the reinstatement requirements of 9.15(2). For example, if a physician's license expires on January 1, the completed reinstatement application is due in the board office by December 31, in order to meet the requirements of this subrule.

9.15(2) Reinstatement of an unrestricted Iowa license that has been inactive for one year or longer. An individual whose license is in inactive status and who has not submitted a reinstatement application that was received by the board within one year of the license's becoming inactive shall follow the application cycle specified in this rule and shall satisfy the following requirements for reinstatement:

a. Submit an application for reinstatement to the board upon forms provided by the board. The application shall require the following information:

(1) Full legal name, date and place of birth, license number, home address, mailing address, principal business address, and personal e-mail address regularly used by the applicant or licensee for correspondence with the board;

(2) A photograph of the applicant suitable for positive identification;

(3) A chronology accounting for all time periods from the date of initial licensure;

(4) Every jurisdiction in which the applicant is or has been authorized to practice including license numbers and dates of issuance;

(5) Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“c” which was completed since the time of initial licensure. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative;

(6) Verification of the applicant's hospital and clinical staff privileges, and other professional experience for the past five years if requested by the board;

(7) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(8) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care. Copies of evaluations, verification of medical condition from treating physicians, or other documentation may be requested if needed during the review process;

(9) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(10) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside. Copies of the legal documents may be requested if needed during the review process; and

(11) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

b. Pay the reinstatement fee plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks specified in 653—paragraph 8.4(1)“f.”

c. Provide documentation of completion of 40 hours of category 1 credit within the previous two years and documentation of training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.

d. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:

- (1) Successfully pass a competency evaluation approved by the board;
- (2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;
- (3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or
- (4) Successfully complete a reentry to practice program or monitoring program approved by the board.

e. An individual who is able to submit a letter from the board with different reinstatement or reactivation criteria is eligible for reinstatement based on those criteria.

9.15(3) Reinstatement application cycle and process. The cycle and process are the same as described in rules 653—9.8(147,148) and 653—9.9(147,148).

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 0215C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14; ARC 2524C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.16(147,148) Reinstatement of a restricted Iowa license. A physician whose license has been suspended or revoked following a disciplinary proceeding is required to seek reinstatement pursuant to 653—Chapter 26.

[ARC 8554B, IAB 3/10/10, effective 4/14/10]

653—9.17(147,148) Denial of licensure or determined to be ineligible for licensure through the IMLC or termination of a license issued through the IMLC.

9.17(1) Preliminary notice of denial. Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

9.17(2) Appeal procedure. An applicant who has received a preliminary notice of licensure denial or a Letter of Qualification that asserts the board has determined that the applicant is ineligible for licensure through the IMLC, or a notice that a medical license is ineligible for renewal through the IMLC, may appeal and request a hearing on the issues related to the preliminary notice of licensure denial or ineligibility for licensure or licensure renewal through the IMLC by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the notice was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure, or a Letter of Qualification that asserts the applicant is eligible for licensure through the IMLC, or the applicant is eligible for licensure renewal through the IMLC.

9.17(3) Hearing. If an applicant appeals the preliminary notice of licensure denial or a determination of ineligibility for licensure or licensure renewal through the IMLC and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with 653—25.30(17A).

a. Hearings for applicants denied licensure, or determined to be ineligible for licensure or licensure renewal through the IMLC are contested cases open to the public.

b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

c. Evidence supporting the denial of the license or the determination of ineligibility for licensure or licensure renewal through the IMLC may be presented by an assistant attorney general.

d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure or licensure eligibility or licensure renewal through IMLC.

e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions or deny the license. The final decision is a public record. After a hearing on ineligibility for licensure renewal through the IMLC, the board may uphold the termination of the license or allow the licensee to renew. The board shall state the reasons for its decision, which is a public record. After a hearing on a Letter of Qualification determination, the board may uphold the ineligible determination or issue a Letter of Qualification asserting the applicant is eligible for licensure through the IMLC. The board shall state the reasons for its decision, which is a public record.

f. Judicial review of a final order of the board denying licensure, issuing a license with restrictions, terminating a license not eligible for renewal through the IMLC, or upholding a Letter of Qualification asserting that an applicant is ineligible for licensure through the IMLC may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

9.17(4) Finality. If an applicant does not appeal a preliminary notice of denial in accordance with 9.17(2), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

9.17(5) Failure to pursue appeal. If an applicant appeals a preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, in accordance with 9.17(2), but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and that the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC becomes final. A final decision under this rule is a public record.

[ARC 7756B, IAB 5/6/09, effective 6/10/09; ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.18(17A,147,148,272C) Waiver requests. Waiver requests shall be submitted in conformance with 653—Chapter 3.

[ARC 8554B, IAB 3/10/10, effective 4/14/10; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—9.19(147,148) Relinquishment of license to practice. A person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine shall be deemed relinquished if the person fails to apply for renewal or reinstatement of the license within five years after its expiration.

9.19(1) A license shall not be reinstated, reissued, or restored once it is relinquished. The person may apply for a new license pursuant to Iowa Code sections 148.3 and 148.11 and 653—Chapters 9 and 10.

9.19(2) The relinquishment of license may be stayed if, at the date of relinquishment, there is an active:

- a.* Evaluation order pursuant to Iowa Code section 272C.9(1) and rule 653—24.4(272);
- b.* Combined statement of charges and settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.3(17A);
- c.* Statement of charges pursuant to Iowa Code section 17A.12(2) and rule 653—25.4(17A);
- d.* Settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.17(272C);

e. Final decision pursuant to Iowa Code sections 17A.12 and 272C.6 and rule 653—25.24(17A); or

f. Application for reinstatement of the license pursuant to rule 653—9.15(147,148) or 653—9.16(147,148).

[ARC 2346C, IAB 1/6/16, effective 2/10/16]

653—9.20(147,148) Administrative medicine licensure.

9.20(1) Application. An application for an administrative medicine license shall be made to the board of medicine pursuant to the requirements established in Iowa Code section 148.3 and this chapter. An applicant for an administrative medicine license shall be subject to all of the permanent licensure requirements established in Iowa Code section 148.3 and this chapter, except that the applicant shall not be required to demonstrate that the applicant has engaged in active clinical practice in the past three years as outlined in paragraphs 9.8(7) “*c*” and 9.15(2) “*d*.”

The board may, in its discretion, issue an administrative medicine license authorizing the licensee to practice administrative medicine only, as defined by this rule. The license shall be designated “administrative medicine license.”

9.20(2) Fees. All license and renewal fees shall be paid to the board in accordance with 653—Chapters 8 and 9.

9.20(3) Demonstration of competence.

a. If an applicant for initial licensure or reinstatement of an administrative medicine license has not actively practiced administrative or clinical medicine in a jurisdiction of the United States or Canada in the past three years, the board may require the applicant to demonstrate competence in a method prescribed by the board in accordance with paragraphs 9.8(7) “*c*” and 9.15(2) “*d*.”

b. A physician who holds an administrative medicine license and has not engaged in active clinical practice in a jurisdiction of the United States or Canada for more than three years may be required to demonstrate competence to practice clinical medicine in a method prescribed by the board in accordance with paragraphs 9.8(7) “*c*” and 9.15(2) “*d*” prior to obtaining a permanent Iowa medical license.

9.20(4) No exemptions to laws and rules. A physician with an administrative medicine license shall be subject to the same laws and rules governing the practice of medicine as a person holding a permanent Iowa medical license.

9.20(5) Only one active license at a time. When applicable, a person’s active Iowa permanent or Iowa resident license shall immediately become inactive upon issuance of an administrative license.

9.20(6) Interstate medical licensure compact. A physician who holds only an administrative medicine license may not be eligible for licensure under the interstate medical licensure compact.

[ARC 2523C, IAB 5/11/16, effective 6/15/16; ARC 3587C, IAB 1/17/18, effective 2/21/18]

653—9.21(147,147B,148) Licensure through IMLC.

9.21(1) Requirements for seeking a Letter of Qualification from the Iowa board of medicine. An applicant shall meet all of the following requirements:

a. Designate Iowa as state of principal license. To designate Iowa as state of principal license, the physician must possess a full, unrestricted, permanent Iowa medical license and meet one of the following requirements at the time the application for a Letter of Qualification is reviewed by board staff:

- (1) Iowa is the physician’s primary residence, or
- (2) At least 25 percent of the physician’s medical practice occurs in Iowa, or
- (3) The physician’s employer is located in Iowa, or
- (4) If the applicant does not meet any of the requirements under (1), (2), or (3), the applicant can designate Iowa as the state of principal license if Iowa is the applicant’s state of residence for the purposes of federal income tax.

b. Provide evidence of the following qualifications:

- (1) Graduation from a medical school accredited by the LCME, COCA, or a medical school listed in the International Medical Education Directory or its equivalent.

(2) Passage of each component of the USMLE or the COMLEX within three attempts, or any of its predecessor examinations accepted by the board as an equivalent examination for licensure purposes as prescribed in rule 653—9.7(147,148).

(3) Successful completion of graduate medical education approved by the ACGME or the AOA. “Successful completion” means participation in an ACGME or AOA postgraduate training program that achieves ABMS or AOA board eligibility status. A one-year transitional internship or a one-year rotating internship does not qualify as graduate medical education required in Iowa Code section 147B.1(2) “k”(3) and IMLC Section 5.4(1) “c.”

(4) Hold specialty certification or a time-unlimited specialty certificate recognized by the ABMS or the AOA. The specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is determined to be eligible for licensure through the IMLC.

(5) Has never been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any criminal offense by a court of appropriate jurisdiction.

(6) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license.

(7) Has never had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration (DEA).

(8) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

9.21(2) Application. A physician seeking licensure through the IMLC who is qualified to designate Iowa as state of principal license shall file an application for a Letter of Qualification with the interstate commission at www.imlcc.org. The application shall require the following:

a. Payment of a nonrefundable service fee to the interstate commission for an application for a Letter of Qualification. This service fee includes the cost for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—subrule 8.3(1); and

b. Completion and submission of forms provided by the board, including required core credentials, documents, a completed fingerprint packet and the criminal history background checks by the DCI and the FBI, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

9.21(3) Letter of Qualification.

a. After receipt of all application materials, the board shall:

(1) Evaluate the applicant’s eligibility for licensure through the IMLC by primary source verification of medical education, graduate medical education, licensing examination results, and other qualifications as determined by IMLC rule;

(2) Perform a criminal background check; and

(3) Issue a Letter of Qualification to the applicant verifying or denying the applicant’s eligibility. The applicant may appeal a determination of eligibility to the Iowa board of medicine within 30 days of issuance of the Letter of Qualification according to the processes outlined in rule 653—9.17(147,148).

b. The Letter of Qualification is valid for a period of 365 days from its date of issuance to request licensure in a member state. During this period, the physician must maintain eligibility to claim Iowa as the state of principal license or designate a new state of principal license.

9.21(4) Expedited licensure. Physicians who have a valid Letter of Qualification may obtain licensure in Iowa through the IMLC. To obtain a permanent Iowa license through the IMLC, a qualified physician shall:

a. Complete the application process at the IMLC’s website, www.imlcc.org.

b. Pay the licensure fee specified in 653—subrule 8.3(2) and any service fees that are required by the IMLC.

c. Comply with the continuing medical education requirements of the board, including mandatory trainings specified in 653—Chapter 11.

9.21(5) *Validity of a license issued through the IMLC.* A license issued through the IMLC is valid for a period consistent with other permanent licenses issued by the board. An Iowa license issued through the IMLC shall be deemed terminated if the licensee fails to maintain a state of principal license.

9.21(6) *Disciplinary actions against licenses issued through the IMLC.*

a. Physicians holding an Iowa license issued through the IMLC are subject to the laws and rules governing the practice of medicine in Iowa.

b. Any disciplinary action taken by another member board of the IMLC against a physician licensed through IMLC shall be deemed unprofessional conduct which may be subject to discipline by the board in addition to any other violation of the board's rules deemed appropriate by the board.

c. If a license issued through the IMLC to a physician is revoked, surrendered, or relinquished in lieu of discipline, or suspended by a member board of the IMLC, then the physician's Iowa expedited license is automatically and immediately suspended, without further action needed, for a period of 90 days upon entry of an order by the board. The 90-day suspension may be terminated early by the board.

d. Any disciplinary action taken by another member board not in the state of principal license may be deemed conclusive as to the matter of law and fact decided, and the board may either impose the same or lesser sanctions against the physician so long as such sanctions are consistent with the board's laws and rules or pursue separate disciplinary action against the physician pursuant to the board's laws and rules.

e. If the Iowa board, as the physician's state of principal license, revokes or suspends the physician's license, or accepts a license surrender in lieu of discipline, then all licenses issued to the physician through the IMLC shall automatically be placed, without further action necessary by any member board, on the same status. If the Iowa board subsequently reinstates the physician's license, the licenses issued by the other member boards shall remain encumbered until the member boards take action to reinstate the licenses.

9.21(7) *Renewal of license issued through the IMLC.* To be eligible for renewal of a license issued through the IMLC, a licensee shall:

a. Complete an online renewal application on a form provided by the IMLC at www.imlcc.org.

b. Complete an attestation that the licensee:

(1) Maintains eligibility to designate a state as the state of principal license, pursuant to paragraph 9.21(1) "a";

(2) Maintains a full and unrestricted license in the designated state of principal license;

(3) Has not been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(4) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(5) Has not had a controlled substance license or permit suspended or revoked by a state or the U.S. DEA.

c. Pay licensure fee for the renewal of a license issued through the IMLC and pay any service fee assessed by the IMLC.

d. If audited, submit verification of completion of continuing medical education requirements set forth in 653—Chapter 11.

9.21(8) *Waivers.* The laws and rules relating to the IMLC cannot be waived.

9.21(9) *Advisory opinions.* The board will recognize advisory opinions issued by the interstate commission on the meaning or interpretation of the IMLC, its bylaws, rules and actions when determining an applicant's eligibility for licensure through the IMLC.

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These rules are intended to implement Iowa Code chapters 17A, 147, 147B, 148, and 272C.

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[◊] Two or more ARCs

CHAPTER 10
RESIDENT, SPECIAL AND TEMPORARY PHYSICIAN LICENSURE

[Prior to 5/30/01, see 653—Chapter 11]

653—10.1(147,148) Definitions.

“*ABMS*” means the American Board of Medical Specialties, which is an umbrella organization for at least 24 medical specialty boards in the United States that assists the specialty boards in developing and implementing educational and professional standards to evaluate and certify physician specialists in the United States. The board recognizes specialty board certification by ABMS.

“*ACGME*” means Accreditation Council for Graduate Medical Education, an accreditation body that is responsible for accreditation of post-medical school training programs in medicine and surgery in the United States of America.

“*AMA*” means the American Medical Association, a professional organization of physicians and surgeons.

“*Any jurisdiction*” means any state, the District of Columbia or territory of the United States of America or any other nation.

“*Any United States jurisdiction*” means any state, the District of Columbia or territory of the United States of America.

“*AOA*” means the American Osteopathic Association, which is the representative organization for osteopathic physicians (D.O.s) in the United States. The board approves osteopathic medical education programs with AOA accreditation; the board approves AOA-accredited resident training programs in osteopathic medicine and surgery at hospitals for graduates of accredited osteopathic medical schools. The board recognizes specialty board certification by AOA. The board recognizes continuing medical education accredited by the Council on Continuing Medical Education of AOA.

“*Applicant*” means a person who seeks authorization to practice medicine and surgery or osteopathic medicine and surgery in this state by making application to the board.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of public health or a training program offered by a hospital, a professional organization for physicians, or the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Board*” means Iowa board of medicine.

“*Board-approved activity*” means one of the following activities:

1. Covering for an Iowa-licensed physician who unexpectedly is unavailable to provide medical care to the physician’s patients;
2. Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa;
3. Conducting a procedure on a patient in Iowa when the consultant’s expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure;
4. Providing medical care to patients in Iowa, if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program;
5. Serving as a camp physician;
6. Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction; or
7. Any other activity approved by the board.

“*Board-approved resident training program*” means a hospital-affiliated graduate medical education program accredited by ACGME, AOA, RCPSA, or CFPC at the time the applicant is enrolled in the program.

“*Category 1 credit*” means any formal education program which is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA

that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*CFPC*” means the College of Family Physicians of Canada.

“*Committee*” means the licensure committee of the board.

“*ECFMG*” means the Educational Commission for Foreign Medical Graduates, an organization that assesses the readiness of international medical school graduates to enter ACGME-approved residency programs in the United States of America.

“*FCVS*” means the Federation Credentials Verification Service, a service under the Federation of State Medical Boards that verifies and stores core credentials for retrieval whenever needed.

“*FSMB*” means the Federation of State Medical Boards, the organization of medical boards of the United States of America.

“*Incidentally called into this state in consultation with a physician and surgeon licensed in this state*” as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as to the care that should be provided, but the consulting physician may not personally perform procedures, write orders, or prescribe for the patient.
4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.
5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient’s care.

“*LCME*” means Liaison Committee on Medical Education, an organization that accredits educational institutions granting degrees in medicine and surgery. The board approves programs that are accredited by LCME.

“*Medical degree*” means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from an international medical school.

“*Permanent licensure*” means licensure granted after review of the application and credentials to determine that the individual is qualified to enter into practice. The individual may only practice when the license is in current, active status.

“*Postgraduate training*” means graduate medical education, e.g., an internship, residency or fellowship, in a hospital-affiliated training program approved by the board at the time the applicant was enrolled in the program.

“*Practice*” means the practice of medicine and surgery or osteopathic medicine and surgery.

“*RCPSC*” means the Royal College of Physicians and Surgeons of Canada.

“*Resident physician*” means a physician enrolled in an internship, residency or fellowship.

“*Resident training program*” means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

“*Service charge*” means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

“*Training for chronic pain management*” means required training on chronic pain management identified in 653—Chapter 11.

“*Training for end-of-life care*” means required training on end-of-life care identified in 653—Chapter 11.

“Training for identifying and reporting abuse” means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69; the full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“Uniform application for physician state licensure” means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure. The Federation of State Medical Boards created and maintains the application. This application is used for all license types issued by the Iowa board of medicine.

[ARC 0216C, IAB 7/25/12, effective 8/29/12]

653—10.2(148) Licensure required. Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in 653—subrule 9.2(2). Provisions for permanent physician licensure are found in 653—Chapter 9; provisions for resident, special and temporary physician licensure are found in this chapter.

653—10.3(147,148) Resident physician licensure.

10.3(1) General provisions.

a. The resident physician license shall authorize the licensee to practice as an intern, resident or fellow while under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery in a board-approved resident training program in Iowa. When the ACGME, AOA, RCPSC, or CFPC fails to offer accreditation for a fellowship or the fellowship fails to seek accreditation, the board shall approve the program if the parent program is accredited by one of the aforementioned accrediting bodies. However, completion of one or more years of a program that itself lacks such accreditation does not fulfill the one-year resident training requirement for permanent licensure.

b. An Iowa resident physician license or an Iowa permanent physician license is required of any resident physician enrolled in an Iowa resident training program and practicing in Iowa.

c. A resident physician license issued on or after February 14, 2003, shall expire on the expected date of completion of the resident training program as indicated on the licensure application. A resident physician license may be extended thereafter at the discretion of the board.

d. A resident physician license is valid only for practice in the program designated in the application. When the physician leaves that program, the license shall immediately become inactive. The director of the resident training program shall notify the board within 30 days of the licensee’s terminating from the program.

e. A resident physician licensee who changes resident training programs shall apply for a new resident physician license as described in subrule 10.3(3). Such changes include a transfer to a different program in the same institution, a move to a program in another institution, or becoming a fellow after completing a residency in the same core program. An individual who contracts with an institution to be in two programs from the time of application for the resident license shall not be required to apply for another resident license for the second program. For example, if a residency requires one year in internal medicine prior to three years in dermatology, the individual may apply initially for a four-year resident license to cover the bundled program. Relicensure is not required if the individual holds a permanent physician license in Iowa.

f. A visiting resident physician may come to Iowa to practice as a part of the physician’s resident training program if the physician is under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary physician license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (see rule 653—10.5(147,148)).

g. An Iowa license is not required for residents when they are training in a federal facility in Iowa. An Iowa license is not required for faculty who are teaching in and employed by a federal facility in Iowa and who are licensed in another state.

h. The director of a resident training program that enrolls a resident with an Iowa resident physician license shall report annually on October 1 on the resident's progress and whether any warnings have been issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action. The board shall inform the program directors on September 1 of the impending deadline.

i. A resident physician licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

j. A resident physician licensee's file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

10.3(2) Resident licensure eligibility. To be eligible for a resident license, an applicant shall meet all of the following requirements:

a. Fulfill the application requirements specified in subrule 10.3(3).

b. Be at least 20 years of age.

c. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board shall be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for the educational institutions granting degrees in medicine and surgery; and

2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant shall:

1. Hold a valid certificate issued by ECFMG, or

2. Have successfully completed a fifth pathway program established in accordance with AMA criteria.

10.3(3) Resident physician licensure application.

a. *Requirements.* To apply for resident physician licensure, an applicant shall:

(1) Pay a nonrefundable application fee of \$100 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI); and

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

b. *Application.* The application shall require the following information:

(1) Full legal name, date and place of birth, home address, and mailing address;

(2) A photograph of the applicant suitable for positive identification;

(3) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(4) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(5) A photocopy of the applicant's medical degree issued by an educational institution.

1. A complete translation shall be submitted for any diploma not written in English. An official transcript, written in English and received directly from the school, verifying graduation from medical school is a suitable alternative. An official FCVS Physician Information Profile is a suitable alternative.

2. If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution;

(6) If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a valid ECFMG certificate or evidence of successful completion of a fifth pathway program in accordance with criteria established by the AMA. An official FCVS Physician Information Profile is a suitable alternative;

(7) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health care facility in any jurisdiction;

(8) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care;

(9) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(10) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(11) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.3(4) *Resident license application review process.* The process below shall be utilized to review each application for a resident license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable resident licensure fee.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may grant administratively a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall grant administratively a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters which include, but are not limited to, falsification of information on the application, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a resident physician license for a particular residency program;

(4) Grant a license under certain terms and conditions or with certain restrictions;

(5) Request that the applicant withdraw the licensure application; or

(6) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a resident physician license for a particular residency program;

(4) Grant a license under certain terms and conditions or with certain restrictions;

- (5) Request that the applicant withdraw the licensure application; or
- (6) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in 653—9.15(147,148).

10.3(5) Resident license application cycle. If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.3(6) Extension of a resident physician license.

a. If the licensee fails to complete the program by the expiration date on the license, the licensee has a one-month grace period in which to complete the program or secure an extension from the board.

b. The resident physician licensee is responsible for applying for an extension if the licensee has not been granted permanent physician licensure and the licensee will not complete the program within the grace period. The following extension application materials are due in the board office prior to the expiration of the license:

- (1) A letter requesting an extension and providing an explanation of the need for an extension;
- (2) The extension fee of \$25; and
- (3) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action.

c. Failure of the licensee to extend a license within one month following the expiration date shall cause the license to become inactive and invalid. For example, a license that expires on June 26 becomes inactive and invalid on July 26. A licensee whose license is inactive is prohibited from practice until the license is extended or replaced by a permanent physician or new resident physician license.

d. To extend an inactive resident license within one year of becoming inactive, an applicant shall submit the following:

- (1) A letter requesting an extension and providing an explanation of the need for an extension;
- (2) The extension fee of \$25;
- (3) A \$50 late fee; and
- (4) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action.

e. If more than one year has passed since the resident license became inactive, the applicant shall apply for a new resident license as described in subrule 10.3(3).

10.3(7) Continuing education and training. Applicants seeking an extension of a resident physician license or an extension of an inactive resident physician license are not required to complete continuing medical education or training requirements as identified in 653—Chapter 11.

10.3(8) Review process for extending a resident license. The process below shall be utilized to review each request for an extension of a resident license.

a. An extension request shall be considered open from the date the required letters and nonrefundable extension fee are received in the board office.

b. After reviewing each request for extension, staff shall notify the licensee or designee about how to resolve any problems identified by the reviewer. The applicant for license extension shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for continued licensure, staff may grant administratively an extension to a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

- (1) If there is no current concern, staff shall grant administratively an extension to a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters which include, but are not limited to, falsification of information in the request, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively an extension to a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Request an investigation;
- (2) Request that the licensee appear for an interview;
- (3) Grant a license under certain terms and conditions or with certain restrictions;
- (4) Request that the licensee withdraw the request for an extension; or
- (5) Deny a request for an extension of the license.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Request an investigation;
- (2) Request that the licensee appear for an interview;
- (3) Grant an extension to the resident physician license;
- (4) Grant an extension to the resident physician license under certain terms and conditions or with certain restrictions;
- (5) Request that the licensee withdraw the request for an extension; or
- (6) Deny a request for an extension of the license. The board may deny an extension of a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial of an extension is set forth in 653—9.15(147,148).

10.3(9) *An Iowa resident physician who changes resident training programs in Iowa.* A resident physician who changes resident training programs shall acquire new resident physician licensure or permanent licensure prior to entering the new resident training program. Such changes include a transfer to a different program in the same institution, a move to a program in another institution, or becoming a fellow after completing a residency in the same core program. An individual who contracts with an institution to be in two programs from the time of application for the resident license shall not be required to apply for another resident license for the second program.

10.3(10) *Discipline of a resident license.* The board may discipline a license for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code section 147.55 or 148.6, Iowa Code chapter 272C, and 653—Chapter 23.

10.3(11) *Transition from a resident license to a permanent license.* When a resident physician receives a permanent Iowa license, the resident physician license shall immediately become inactive.

[ARC 0216C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—10.4(147,148) Special licensure.

10.4(1) *General provisions.*

a. The board may grant a special license to a physician who is an academic staff member of a college of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure, but is held in high esteem for unique contributions the individual has made to medicine and will make by practicing in Iowa. The license is not designed for physicians in regular faculty positions that could be filled by a physician qualified for permanent licensure in Iowa or for the purpose of training the physician who receives the license, i.e., participating in a fellowship of any kind. The board will consider granting and renewing a special license on a case-by-case basis.

b. A special license may be issued for a period of not more than one year and may be renewed annually prior to expiration. The number of renewals granted by the board is not limited. The renewal of any special license granted for the first time after July 1, 2001, shall be limited to those physicians who continue to meet the requirements of paragraph “a” of this subrule and subrule 10.4(5). Academic

institutions are encouraged to assist special licensees in qualifying for permanent licensure if the physician is to remain in Iowa long term.

c. A special license shall specifically limit the licensee to practice at the medical college and at any health care facility affiliated with the medical college.

d. A special license shall automatically be placed on inactive status when the licensee discontinues service on the academic medical staff for which the special license was granted.

e. The board may cancel a special license if the licensee has practiced outside the scope of this license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. When cancellation of such a license is proposed, the board shall promptly notify the licensee by sending a statement of charges and notice of hearing by certified mail to the last-known address of the licensee. This contested case proceeding shall be governed by the provisions of 653—Chapter 25.

f. A special physician licensee shall notify the board of any change in home address or the address of the place of practice within one month of making an address change.

g. A special physician licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

h. A special physician licensee file shall be closed and labeled “deceased” when the board receives a copy of the physician’s death certificate.

i. The board shall accept each 12 months of practice as a special licensee as equivalent to one year of postgraduate training in a hospital-affiliated program approved by the board for the purposes of permanent licensure.

10.4(2) *Special license eligibility.* To be eligible for a special license, an applicant shall meet all of the following requirements:

- a.* Fulfill the application requirements specified in subrule 10.4(3);
- b.* Be at least 21 years of age;
- c.* Be a physician in a medical specialty;
- d.* Present evidence of holding a medical degree from an educational institution that is located in a jurisdiction outside the United States or Canada and that is listed in the Directory of Medical Schools published by the International Medical Education Directory;
- e.* Have completed at least two years of postgraduate education in any jurisdiction;
- f.* Have practiced for five years after postgraduate education;
- g.* Demonstrate English proficiency as set forth in subparagraph 10.4(3) “a”(4); and
- h.* Be licensed in a jurisdiction outside the United States or Canada and present evidence that any licenses held in any jurisdiction are unrestricted.

10.4(3) *Special license application.*

a. Requirements. To apply for a special license an applicant shall:

(1) Pay a nonrefundable special license fee of \$300 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks;

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

(3) Provide verification of successful completion of a medical degree;

(4) Demonstrate proficiency in English by providing a valid ECFMG certificate or verification of a passing score on the TSE, the Test of Spoken English, or TOEFL, the Test of English as a Foreign Language, examinations administered by the Educational Testing Service. A passing score on TSE is a minimum of 50. A passing score on TOEFL is a minimum overall score of 550 on the paper-based TOEFL that was administered on a Friday or Saturday (formerly special or international administration), a minimum overall score of 213 on the computer-administered TOEFL, or a minimum overall score of 79 on the Internet-based examination;

(5) Present a letter from the dean of the medical college in which the applicant will be practicing that indicates all of the following:

1. The applicant has been invited to serve on the academic staff of the medical school and in what capacity;

2. The applicant's qualifications and the unique contributions the applicant has made to the practice of medicine;

3. The unique contributions the applicant is expected to make by practicing in Iowa and how these contributions will serve the public interest of Iowans; and

(6) Present at least two letters of recommendation from universities, other educational institutions, or research facilities that indicate the applicant's noteworthy professional attainment.

b. Application. The application shall request the following information:

(1) Name, date and place of birth, home address, and mailing address;

(2) A photograph of the applicant suitable for positive identification;

(3) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(4) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(5) A photocopy of the applicant's medical degree issued by an educational institution and a sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. A complete translation of any diploma not written in English shall be submitted;

(6) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(7) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care;

(8) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(9) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(10) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.4(4) *Special license application review process.* The process below shall be utilized to review each application for a special license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable special licensure fee.

b. After reviewing each application, staff shall notify the applicant or the applicant's academic institution about how to resolve any problems identified by the reviewer. The applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant a special license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively grant a special license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters which include, but are not limited to, falsification of information on the application, criminal record, substance abuse, questionable competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a special license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Request that the applicant appear for an interview;
- (2) Grant a special license for practice at the medical college designated in the application;
- (3) Grant a license under certain terms and conditions or with certain restrictions;
- (4) Request that the applicant withdraw the licensure application; or
- (5) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Request that the applicant appear for an interview;
- (2) Grant a special license for practice at the medical college designated in the application;
- (3) Grant a license under certain terms and conditions or with certain restrictions;
- (4) Request that the applicant withdraw the licensure application; or
- (5) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in 653—9.15(147,148).

10.4(5) *Special license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.4(6) *Renewal of a special license.*

a. If the special physician licensee has not qualified for and received a permanent license, the board shall send a courtesy renewal notice by regular mail to the licensee's last-known address at least 60 days prior to the expiration date of the special physician license. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

b. A special physician licensee shall apply for a one-year renewal by submitting the following:

- (1) A completed renewal application;
- (2) The renewal fee of \$200; and
- (3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse.

1. The requirement for continuing education is 20 hours of category 1 credit as specified in 653—Chapter 11.

2. The requirement for training on chronic pain management, end-of-life care, and identifying and reporting abuse is specified in 653—Chapter 11.

The dean of the medical college shall submit a letter that addresses the individual's unique contribution to the practice of medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license. For a licensee who received the initial special license prior to July 1, 2001, the only statement needed from the dean is verification of the academic appointment the licensee continues to hold.

c. Failure of the licensee to renew a license within one month of the expiration date shall cause the license to become inactive. A licensee whose license is inactive is prohibited from practice until a new special license is granted according to subrules 10.4(3) and 10.4(4).

[ARC 0216C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—10.5(147,148) Temporary licensure. The board may issue a temporary license authorizing a physician to participate in a board-approved activity in Iowa. Temporary licensure is granted on a case-by-case basis and depends upon the applicant's education and training, experience and licensure status elsewhere and upon the intended use of the temporary license.

10.5(1) General provisions.

a. The temporary license to practice is intended for a physician to participate in a board-approved activity, as defined in rule 653—10.1(147,148), in Iowa that is short-term. Temporary licensure is not intended to be a way for a physician to practice before a permanent license is granted. Temporary licensure is not intended for locum tenens.

b. The board may issue a temporary license authorizing the physician to practice in a board-approved activity. The license may be restricted to the board-approved activity, location(s) or time period of up to one year.

(1) A physician who is granted a temporary license for a board-approved activity may qualify for renewal of that license if the physician needs an extension of the license for the original purpose or to pursue more than one board-approved activity within a year.

(2) A physician who wishes to continue in a board-approved activity in Iowa for short intervals beyond one year is eligible for a temporary license each year after reapplying and qualifying on an annual basis.

c. A physician incidentally called into this state in consultation with a physician and surgeon licensed in this state, as defined in rule 653—10.1(147,148), is not required to obtain a temporary license in Iowa.

d. A physician who seeks to practice in Iowa and does not qualify for a temporary license may be eligible for permanent licensure under 653—Chapter 9.

e. The board may take disciplinary action on a temporary license if the licensee has practiced outside the scope of the temporary license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. Contested case proceedings shall be governed by the provisions of 653—Chapter 25.

f. A physician who holds a temporary license shall notify the board of any change in address within three days of making an address change.

g. A physician who holds a temporary license shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

h. The file of a physician who holds a temporary license shall be closed and labeled “deceased” when the board receives a copy of the physician’s death certificate.

10.5(2) Eligibility for a temporary license. To be eligible for a temporary license, an applicant shall meet all of the following requirements:

a. Fulfill the requirements specified in subrules 10.5(3) and 10.5(4);

b. Be at least 21 years of age;

c. Hold a medical degree from an educational institution approved by the board (if the applicant is an international medical graduate, the educational institution must be listed in the International Medical Education Directory);

d. Hold a current active, unrestricted license to practice medicine issued by any jurisdiction;

e. Be fluent in the English language;

f. Present a letter justifying the need for temporary licensure from the organization or individual seeking the applicant’s participation in a board-approved activity.

10.5(3) Requirements for a temporary license. To apply for a temporary license, an applicant shall complete the requirements in paragraphs “a” and “b”:

a. Pay a nonrefundable application fee of \$100 plus the \$45 fee identified in 653—subrule 8.4(6) for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI). A physician who is serving as a camp physician and who is not receiving payment other than expenses shall be exempt from the license application fee and the fee for the criminal history background check.

b. Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

10.5(4) Application. The application shall require the following information:

- a. The applicant's full legal name, date and place of birth, home address, mailing address and principal business address;
- b. A photograph of the applicant suitable for positive identification;
- c. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including the applicant's license number and date of issuance of the license;
- d. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;
- e. A statement by the applicant that discloses and explains any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;
- f. A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care;
- g. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;
- h. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant, filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;
- i. A statement from the applicant that justifies the need for a temporary license, including where the applicant intends to practice and the type of practice involved;
- j. A letter from the Iowa organization or individual seeking the applicant's services that explains the need for the applicant's participation in the board-approved activity in Iowa, the time period involved, the scope of practice, and the exact location and facilities where the board-approved activity will occur;
- k. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction, a statement, which shall be submitted by the Iowa organization or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be;
- l. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction:
 - (1) Verification, which shall be submitted from the licensing authority of the country in which the physician is licensed, that the physician has a license in good standing;
 - (2) Evidence of fluency in the English language;
- m. For a resident physician who does not hold a current, active resident or permanent license in the home state of the resident training program, a statement, which shall be submitted by the resident director or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be.
- n. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.5(5) *Standard application review process for a temporary license.* The standard review process shall be utilized to review each application for a temporary license, except that the process identified in subrule 10.5(6) shall be used for any international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or for any physician who seeks temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). The standard application review process is as follows:

- a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.
- b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.
- c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary licensee, staff may administratively grant a temporary

license to the applicant for a specific activity, location(s) or specified duration based on the nature of the board-approved activity. The license shall not be granted for a period longer than one year.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, then the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for temporary licensure or the organization's or requesting individual's need for a licensee with a temporary license.

- (1) If there is no current concern, staff shall administratively grant a temporary license.
- (2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include, but are not limited to, falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, educational disciplinary history, or questionable need on the part of the organization.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to administratively grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;
- (3) Deny a temporary license; or
- (4) Request that the applicant withdraw the temporary licensure application.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;
- (3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or
- (4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in 653—9.17(147,148).

10.5(6) *Application review process for applicants with certain exceptions.* This application process shall be used to review applications submitted by an international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or by a physician seeking temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). Following is the application review process for applicants with exceptions:

a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary license, staff shall submit the application to the committee for review and recommendation to the board about whether to grant a temporary license to the physician and whether the license should be granted for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

d. The board shall consider applications and recommendations from the committee and shall:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;

(3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or

(4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in 653—9.17(147,148).

10.5(7) Temporary license application cycle. If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status. An applicant whose application is inactive must reapply and submit new nonrefundable fees and a new application, documents and credentials if the applicant wishes to pursue temporary licensure.

10.5(8) Renewal of a temporary license.

a. When the temporary license is granted, the board shall inform the licensee that the license may be renewed within the year, if the same need for a temporary license continues. The board shall not send a notice of renewal.

b. To apply for renewal of a temporary license, the licensee shall submit the following:

- (1) A request for renewal;
- (2) The renewal fee of \$50; and
- (3) Written justification for the renewal from the organization or individual seeking the applicant.

Failure of the licensee to renew a license by the expiration date shall cause the license to become inactive. The individual shall not practice in Iowa until securing a permanent medical license or until becoming eligible for a second temporary license.

[ARC 0216C, IAB 7/25/12, effective 8/29/12; ARC 1187C, IAB 11/27/13, effective 1/1/14]

653—10.6(17A,147,148,272C) Waiver requests. Waiver requests shall be submitted in conformance with 653—Chapter 3.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

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[◇] Two or more ARCs

CHAPTER 11
CONTINUING EDUCATION AND
TRAINING REQUIREMENTS

[Prior to 5/4/88, see 470—135.101 to 470—135.110 and 135.501 to 135.512]

653—11.1(272C) Definitions.

“*ABMS*” means the American Board of Medical Specialties, which is an umbrella organization for at least 24 medical specialty boards in the United States that assists the specialty boards in developing and implementing educational and professional standards to evaluate and certify physician specialists in the United States. The board recognizes specialty board certification by ABMS.

“*Accredited provider*” means an organization approved as a provider of category 1 credit by one of the following board-approved accrediting bodies: Accreditation Council for Continuing Medical Education, Iowa Medical Society, or the Council on Continuing Medical Education of the AOA.

“*Active duty*” means full-time training or active service in the U.S. armed forces, reserves or national guard.

“*Active licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in Iowa who has met all conditions of licensure and maintains a current license to practice in Iowa.

“*AMA*” means the American Medical Association, a professional organization of physicians and surgeons.

“*AOA*” means the American Osteopathic Association, which is the representative organization for osteopathic physicians (D.O.s) in the United States. The board approves osteopathic medical education programs with AOA accreditation; the board approves AOA-accredited resident training programs in osteopathic medicine and surgery at hospitals for graduates of accredited osteopathic medical schools. The board recognizes specialty board certification by AOA. The board recognizes continuing medical education accredited by the Council on Continuing Medical Education of AOA.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of public health or a training program offered by a hospital, a professional organization for physicians, or the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Approved program or credit*” means any category 1 credit offered by an accredited provider or any other program or credit meeting the standards set forth in these rules.

“*Board*” means the Iowa board of medicine.

“*Carryover*” means hours of category 1 credit earned in excess of the required hours in a license period that may be applied to the continuing education requirement in the subsequent license period; carryover may not exceed 20 hours of category 1 credit per renewal cycle.

“*Category 1 credit*” means any formal education program which is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of the AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*Committee*” means the licensure committee of the board.

“*COMVEX-USA*” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America. The National Board of Osteopathic Medical Examiners prepares the examination and determines its passing score. A licensing authority in any jurisdiction administers the examination. COMVEX-USA is the current evaluative instrument offered to osteopathic physicians who need to demonstrate current osteopathic medical knowledge.

“*Continuing education*” means education that is acquired by a licensee in order to maintain, improve, or expand skills and knowledge present at initial licensure or to develop new and relevant skills and knowledge.

“*Hour of continuing education*” means a clock hour spent by a licensee in actual attendance at or completion of an approved category 1 credit.

“*Inactive license*” means any license that is not a current, active license. Inactive license may include licenses formerly known as delinquent, lapsed, or retired. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reinstated.

“*Licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa.

“*Opioid*” means any FDA-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Service charge*” means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

“*SPEX*” means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

“*Training for chronic pain management*” means required training on chronic pain management identified in 653—Chapter 11.

“*Training for end-of-life care*” means required training on end-of-life care identified in 653—Chapter 11.

“*Training for identifying and reporting abuse*” means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively. The full requirements on reporting of child abuse and the training requirements are in Iowa Code section 232.69; the full requirements on reporting of dependent adult abuse and the training requirements are in Iowa Code section 235B.16.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 4338C, IAB 3/13/19, effective 4/17/19]

653—11.2(272C) Continuing education credit and alternatives.

11.2(1) Continuing education credit may be obtained by attending category 1 credits as defined in this chapter.

11.2(2) The board shall accept the following as equivalent to 50 hours of category 1 credit: participation in an approved resident training program or board certification or recertification by an ABMS or AOA specialty board within the licensing period.

11.2(3) The board shall in January of each year recognize the equivalent of up to 10 hours of category 1 credits for physicians who actively served as members or alternate members of the Iowa board of medicine during the previous year; for physicians who actively served as members of the Iowa physician health committee during the previous year; and for physicians who performed peer reviews for the board during the previous year. The physicians receiving recognition of category 1 credit equivalents will be notified by U.S. mail in January by the executive director of the board.

[ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.3(272C) Accreditation of providers. The board approves the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, and the Council on Continuing Medical Education of the AOA as organizations acceptable to accredit providers of category 1 credits.

[ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.4(272C) Continuing education and training requirements for renewal or reinstatement. A licensee shall meet the requirements in this rule to qualify for renewal of a permanent license, an

administrative medicine license, or special license or to qualify for reinstatement of a permanent license or an administrative medicine license.

11.4(1) Continuing education and training requirements.

a. Continuing education for permanent license or administrative medicine license renewal. Except as provided in these rules, a total of 40 hours of category 1 credit or board-approved equivalent shall be required for biennial renewal of a permanent license or an administrative medicine license. This may include up to 20 hours of credit carried over from the previous license period and category 1 credit acquired within the current license period.

(1) To facilitate license renewal according to birth month, a licensee's first license may be issued for less than 24 months. The number of hours of category 1 credit required of a licensee whose license has been issued for less than 24 months shall be reduced on a pro-rata basis.

(2) A licensee desiring to obtain credit for carryover hours shall report the carryover, not to exceed 20 hours of category 1 credit, on the renewal application.

b. Continuing education for special license renewal. A total of 20 hours of category 1 credit shall be required for annual renewal of a special license. No carryover hours are allowed.

c. Training for identifying and reporting child and dependent adult abuse for permanent or special license renewal. The licensee in Iowa shall complete the training for identifying and reporting child and dependent adult abuse as part of a category 1 credit or an approved training program. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1)"a."

(1) Training to identify child abuse. A licensee who regularly provides primary health care to children in Iowa must complete at least two hours of training provided by the department of human services pursuant to Iowa Code section 232.69(3)"c" in child abuse identification and reporting every three years. If a licensee completes at least one hour of additional child abuse identification and reporting training prior to the three-year expiration period, the licensee shall be deemed in compliance with the training requirements of this subparagraph for an additional three years. "A licensee who regularly provides primary health care to children" means all emergency physicians, family physicians, general practice physicians, pediatricians, and psychiatrists, and any other physician who regularly provides primary health care to children.

(2) Training to identify dependent adult abuse. A licensee who regularly provides primary health care to adults in Iowa must complete at least two hours of training provided by the department of human services pursuant to Iowa Code section 235B.16(5)"c" in dependent adult abuse identification and reporting every three years. If a licensee completes at least one hour of additional dependent adult abuse identification and reporting training prior to the three-year expiration period, the licensee shall be deemed in compliance with the training requirements of this subparagraph for an additional three years. "A licensee who regularly provides primary health care to adults" means all emergency physicians, family physicians, general practice physicians, internists, obstetricians, gynecologists, and psychiatrists, and any other physician who regularly provides primary health care to adults.

d. Training for chronic pain management for permanent or special license renewal. The licensee shall complete the training for chronic pain management as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1)"a."

(1) A licensee who has prescribed opioids to a patient during the previous license period must complete at least two hours of category 1 credit regarding the United States Centers for Disease Control and Prevention (CDC) guideline for prescribing opioids for chronic pain, including recommendations on limitations on dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options, every five years. A licensee may attest as part of the license renewal process that the licensee is not subject to the requirement to receive continuing medical education credits pursuant to this paragraph, due to the fact that the licensee did not prescribe opioids to a patient during the previous licensure cycle.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the chronic pain management training and shall then complete the training once every five years thereafter.

e. Training for end-of-life care for permanent or special license renewal. The licensee shall complete the training for end-of-life care as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1) “a.”

(1) A licensee who regularly provides direct patient care to actively dying patients in Iowa must complete at least two hours of category 1 credit for end-of-life care every five years.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the end-of-life care training and shall then complete the training once every five years thereafter.

11.4(2) Exemptions from renewal requirements.

a. A licensee shall be exempt from the continuing education requirements in subrule 11.4(1) when, upon license renewal, the licensee provides evidence for:

(1) Periods that the licensee served honorably on active duty in the U.S. armed forces, reserves or national guard;

(2) Periods that the licensee practiced in another state or district and did not provide medical care, including telemedicine services, to patients located in Iowa, if the other state or district had continuing education requirements for the profession and the licensee met all requirements of that state or district for practice therein;

(3) Periods that the licensee was a government employee working in the licensee’s specialty and assigned to duty outside the United States; or

(4) Other periods of active practice and absence from the state approved by the board.

b. The requirements for training on chronic pain management and end-of-life care for license renewal shall be suspended for a licensee who provides evidence for:

(1) Periods described in subparagraph 11.4(2) “a”(1), (2), (3), or (4); or

(2) Periods that the licensee resided outside of Iowa and did not practice in Iowa.

11.4(3) Extension for completion of or exemption from renewal requirements. The board may, in individual cases involving physical disability or illness, grant an extension of time for completion of, or an exemption from, the renewal requirements in subrule 11.4(1).

a. A licensee requesting an extension or exemption shall complete and submit a request form to the board that sets forth the reasons for the request and has been signed by the licensee and attending physician.

b. The board may grant an extension of time to fulfill the requirements in subrule 11.4(1).

c. The board may grant an exemption from the educational requirements for any period of time not to exceed one calendar year.

d. If the physical disability or illness for which an extension or exemption was granted continues beyond the period of waiver, the licensee must reapply for a continuance of the extension or exemption.

e. The board may, as a condition of any extension or exemption granted, require the applicant to make up a portion of the continuing education requirement by methods it prescribes.

11.4(4) Reinstatement requirement. An applicant for license reinstatement whose license has been inactive for one year or more shall provide proof of successful completion of 40 hours of category 1 credit completed within 24 months prior to submission of the application for reinstatement or proof of successful completion of SPEX or COMVEX-USA within one year immediately prior to the submission of the application for reinstatement.

11.4(5) Cost of continuing education and training for renewal or reinstatement. Each licensee is responsible for all costs of continuing education and training required in 653—Chapter 11.

11.4(6) Documentation. A licensee shall maintain documentation of the continuing education and training requirements in 653—Chapter 11, including dates, subjects, duration of programs, and proof of participation, for five years after the date of the continuing education and training.

11.4(7) Audits. The board may audit continuing education and training documentation at any time within the five- or three-year period, as applicable. If the board conducts an audit of continuing education and training, a licensee shall respond to the board and provide all materials requested, within 30 days of a request made by board staff or within the extension of time if one has been granted.

11.4(8) Grounds for discipline. A licensee may be subject to disciplinary action for failure to comply with continuing education and training requirements in 653—Chapter 11.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 2523C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 4338C, IAB 3/13/19, effective 4/17/19; ARC 4978C, IAB 3/11/20, effective 4/15/20]

653—11.5(272C) Failure to fulfill requirements for continuing education and training for identifying and reporting abuse.

11.5(1) Disagreement over whether material submitted fulfills the requirements specified in rule 653—11.4(272C).

a. Staff will attempt to work with a licensee or applicant to resolve any discrepancy concerning credit for renewal or reinstatement.

b. When resolution is not possible, staff shall refer the matter to the committee.

(1) In the matter of a licensee seeking license renewal, staff shall renew the license if all other matters are in order and inform the licensee that the matter is being referred to the committee.

(2) In the matter of an applicant seeking reinstatement, staff shall reinstate the license if all other matters are in order and inform the applicant that the matter is being referred to the committee.

c. The committee shall consider the staff's recommendation for denial of credit for continuing education or training for identifying and reporting abuse, chronic pain management, and end-of-life care.

(1) If the committee approves the credit, it shall authorize the staff to inform the licensee or applicant that the matter is resolved.

(2) If the committee disapproves the credit, it shall refer the matter to the board with a recommendation for resolution.

d. The board shall consider the committee's recommendations.

(1) If the board approves the credit, it shall authorize the staff to notify the licensee or applicant for reinstatement if all other matters are in order.

(2) If the board denies the credit, it shall:

1. Close the case;

2. Send the licensee or applicant an informal, nonpublic letter of warning, which may include recommended terms for complying with the requirements for continuing education or training; or

3. File a statement of charges for noncompliance with the board's rules on continuing education or training and for any other violations which may exist.

11.5(2) Informal appearance for failure to complete requirements for continuing education or training.

a. The licensee or applicant may, within ten days after the date that the notification of the denial was sent by certified mail, request an informal appearance before the board.

b. At the informal appearance, the licensee or applicant will have the opportunity to present information, and the board will issue a written decision.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.6(17A,147,148E,272C) Waiver requests. Waiver requests shall be submitted in conformance with 653—Chapter 3.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapters 147 and 272C and sections 232.69 and 235B.16.

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¹ Paragraph 11.4(1)“d” rescinded by 2018 Iowa Acts, House File 2377, section 23, effective 7/1/18.

CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

13.1(2) A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

653—13.2(124,148,272C) Standards of practice—appropriate pain management. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy, including but not limited to adjunct therapies such as acupuncture, physical therapy and massage, osteopathic manipulative therapy and occupational therapy in the treatment of acute and chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.

3. The board recognizes that pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

4. Physicians should not fear board action for treating pain with opioids as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

5. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(1) Definitions. For the purposes of this rule, the following terms are defined as follows:

“Acute pain” means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

“Addiction” means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors

that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

“*Chronic pain*” means pain that typically lasts longer than three months or past the time of normal tissue healing. Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause.

“*Opioid*” means any U.S. Food and Drug Administration (FDA)-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Pain*” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

“*Physical dependence*” means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

“*Pseudoaddiction*” means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

“*Substance abuse*” means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

“*Tolerance*” means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

“*Undertreatment of pain*” means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(2) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

13.2(3) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician’s concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(4) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient’s medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain.

c. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. A

physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the CDC Guideline for Prescribing Opioids for Chronic Pain.

13.2(5) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for opioids from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of opioids with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral. A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, and other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements. A physician who treats patients for chronic pain with opioids shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with opioids. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes opioids to a patient for more than 90 days for the treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. Sample pain management agreement and prescription drug risk assessment tools may be found on the board's website at www.medicalboard.iowa.gov.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care. The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(6) Pain management for terminal illness. The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(7) Prescription monitoring program. The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections 124.551 to 124.558 to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. A physician shall register for the prescription monitoring program at the same time the physician applies for registration or renews registration to prescribe controlled substances as required by the Iowa board of pharmacy. A physician or the physician's designated agent shall utilize the prescription monitoring program prior to issuing an opioid prescription to assist the physician in determining appropriate treatment options and to improve the quality of patient care. A physician is not required to utilize the prescription monitoring program to assist in the treatment of a patient receiving inpatient hospice care or long-term residential facility patient care. An order issued in an inpatient hospital setting is not considered a prescription for the purposes of these rules. Patient safety is adequately protected in an inpatient hospital setting, and physicians caring for patients in an inpatient hospital setting do not prescribe. A link to the prescription monitoring program may be found at the board's website at www.medicalboard.iowa.gov.

13.2(8) Electronic prescriptions. Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) shall be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

13.2(9) Pain management resources. The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the

convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued a guideline to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

13.2(10) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 653—Chapter 23, or any of the following:

a. A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.

b. A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.

c. A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

13.2(11) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class “D” felony. This subrule shall not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.

This rule is intended to implement Iowa Code chapters 124, 148 and 272C.

[ARC 9599B, IAB 7/13/11, effective 8/17/11; ARC 2705C, IAB 9/14/16, effective 10/19/16; ARC 4714C, IAB 10/23/19, effective 11/27/19]

653—13.3(147) Supervision of pharmacists who administer adult immunizations. Rescinded ARC 1033C, IAB 10/2/13, effective 11/6/13.

653—13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management. A supervising physician may only delegate aspects of drug therapy management to an authorized pharmacist pursuant to a written protocol with a pharmacist pursuant to the requirements of this rule. The physician is considered the supervisor and retains the ultimate responsibility for the care of the patient. The authorized pharmacist retains full responsibility for proper execution of pharmacy practice.

13.4(1) Definitions.

“Authorized pharmacist” means an Iowa-licensed pharmacist who meets the training requirements of the Iowa board of pharmacy (IBP) as specified in the drug therapy management criteria in 657—8.34(155A).

“Board” means the board of medicine of the state of Iowa.

“Collaborative drug therapy management” means participation by a physician and an authorized pharmacist in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

“Collaborative practice” means that a physician may delegate aspects of drug therapy management for the physician’s patients to an authorized pharmacist through a written community practice protocol. “Collaborative practice” also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and the hospital’s clinic patients through a hospital practice protocol when the clinic and the pharmacist are under the direct authority of the hospital’s P&T committee.

“Community practice protocol” means a written, executed agreement entered into voluntarily between a physician and an authorized pharmacist establishing drug therapy management for one or more of the physician’s patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 13.4(2).

“Community setting” means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

“Hospital clinic” means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital’s P&T committee.

“Hospital pharmacist” means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital’s P&T committee.

“Hospital practice protocol” means a written plan, policy, procedure, or agreement that authorizes drug therapy management between physicians and hospital pharmacists within a hospital and its clinics as developed and determined by its P&T committee. Such a protocol may apply to all physicians and hospital pharmacists at a hospital or the hospital’s clinics under the direct authority of the hospital’s P&T committee or only to those physicians and pharmacists who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 13.4(3).

“IBP” means the Iowa board of pharmacy.

“P&T committee” means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

“Physician” means a person who is currently licensed in Iowa to practice medicine and surgery or osteopathic medicine and surgery. A physician who executes a written protocol with an authorized pharmacist shall supervise the pharmacist’s activities involved in the overall management of patients receiving medications or disease management services under the protocol. The physician may delegate only drug therapies that are in areas common to the physician’s practice.

“Therapeutic interchange” means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

13.4(2) Community practice protocol.

a. A physician shall engage in collaborative drug therapy management with a pharmacist only under a written protocol that is identified by topic and has been submitted to the IBP or a committee authorized by the IBP. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

b. The community practice protocol shall include:

(1) The name, signature, date and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a particular patient. If more than one authorized pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal pharmacist shall be designated in the protocol.

(2) The name, signature, date and contact information for each physician who may prescribe drugs and is responsible for supervising a patient's drug therapy management. The physician who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal physician.

(3) The name and contact information of the principal physician and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

(4) A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration and route of administration of the drug authorized by the patient's physician. The protocol shall not authorize the pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the patient's physician for follow-up.

4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

(5) Procedures for the physician to secure the patient's written consent. If the physician does not secure the patient's written consent, the pharmacist shall secure such and notify the patient's physician within 24 hours.

(6) Circumstances that shall cause the pharmacist to initiate communication with the physician, including but not limited to the need for new prescription orders and reports of the patient's therapeutic response or adverse reaction.

(7) A detailed statement identifying the specific drugs, laboratory tests and physical findings upon which the pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy protocol to be reviewed, updated and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist's decisions or recommendations for the physician.

(10) A description of the types of reports the physician requires the pharmacist to provide and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame in which a pharmacist shall report any adverse reaction to the physician.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits a physician from delegating collaborative drug therapy management to any unlicensed or licensed person other than another physician or authorized pharmacist.

(17) A description of the mechanism for the pharmacist and physician to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

c. Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least the patient's physician and one authorized pharmacist.

d. A collaborative drug therapy management protocol must be filed with the IBP, kept on file in the pharmacy and made available to the board or IBP upon request. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

e. A physician may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the physician notifies, in writing, the pharmacist and the IBP. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. After July 1, 2008, the physician shall no longer be required to notify the IBP of changes in the protocol.

f. Patient consent for community practice protocols. The physician or pharmacist who initiates a protocol with a patient is responsible for securing a patient's written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient needs to be communicated to the other party at the time of securing the patient's consent. The patient's physician shall maintain the patient consent in the patient's medical record.

13.4(3) Hospital practice protocol.

a. A hospital's P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by its hospital pharmacists in the hospital and its clinics. Hospital clinics are restricted to outpatient care clinics operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

b. Collaborative drug therapy management within a hospital setting or the hospital's clinic setting is valid only when approved by the hospital's P&T committee.

c. The hospital practice protocol shall include:

(1) The names or groups of physicians and pharmacists who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration and route of administration of the drug authorized by the physician. The protocol shall not authorize the hospital pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the physician for follow-up.

(4) Circumstances that shall cause the hospital pharmacist to initiate communication with the patient's physician, including but not limited to the need for new medication orders and prescription drug orders and reports of a patient's therapeutic response or adverse reaction.

(5) A statement of the medication categories and the type of initiation and modification of drug therapy that the protocol authorizes the hospital pharmacist to perform.

(6) A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

(7) A description of the mechanism for the hospital pharmacist and the patient's physician to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

This rule is intended to implement Iowa Code chapter 148.

653—13.5(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147 and 148.

653—13.6(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.6(1) An internal quality control assurance plan shall include the following elements:

- a. The name of the physician responsible for the internal quality assurance plan and testing;
- b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;
- c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e. Staff training and qualifications for dispensing via the dispensing system;
- f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;
- h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i. A plan for interval testing of the accuracy of dispensing, at least annually; and
- j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.6(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.6(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph "i."

653—13.7(147,148,272C) Standards of practice—office practices.

13.7(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall

provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.7(2) Patient referrals. A physician shall not pay or receive compensation for patient referrals.

13.7(3) Confidentiality. A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.7(4) Sexual conduct. It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor, regardless of whether the patient consents to that conduct.

13.7(5) Disruptive behavior: A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.7(6) Sexual harassment. A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature which interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.7(7) Transfer of medical records. A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.7(8) Retention of medical records. The following paragraphs become effective on January 1, 2004.

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Upon a physician's death or retirement, the sale of a medical practice or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

653—13.8(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa.

13.8(1) Definitions. As used in this rule:

“*Alter*” means to change the cellular structure of living tissue.

“*Capable of*” means any means, method, device or instrument which, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

“*Damage*” means to cause a harmful change in the cellular structure of living tissue.

“*Delegate*” means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

“*Medical aesthetic service*” means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

“*Medical director*” means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

“*Medical spa*” means any entity, however organized, which is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice which is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

“*Nonsuperficial*” means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

“*Qualified laser technician*” means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

“*Qualified licensed or certified nonphysician person*” means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

“*Supervision*” means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

13.8(2) Practice of medicine. The performance of medical aesthetic services is the practice of medicine. A medical aesthetic service shall only be performed by qualified licensed or certified

nonphysician persons or qualified laser technicians if the service has been delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa.

13.8(3) *Medical director.* A physician who serves as medical director at a medical spa shall:

- a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;
- b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;
- c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and
- e. Be clearly identified as the medical director in all advertising activities, Internet websites and signage related to the medical spa.

13.8(4) *Delegated medical aesthetic service.* When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

- a. Within the medical director's scope of practice and medical competence to supervise;
- b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and
- c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

13.8(5) *Supervision.* A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

- a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person's education, training, experience and ability;
- b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services which are beyond the scope of that person's license or certification unless the person is supervised by a qualified supervising physician;
- c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician at least four hours each week and that the regular supervision is documented;
- d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;
- f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;
- g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;
- h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;
- j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or

certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

13.8(6) Continuing medical education. All medical directors, qualified licensed or certified nonphysician persons and qualified laser technicians who practice at a medical spa in Iowa shall complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

13.8(7) Exceptions. This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

13.8(8) Physician assistants. Nothing in this rule shall be interpreted to contradict or supersede the rules established in 645—Chapters 326 and 327.

[ARC 9088B, IAB 9/22/10, effective 10/27/10; ARC 4247C, IAB 1/16/19, effective 2/20/19]

653—13.9(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.9(1) Definition. As used in this rule:

“*Interventional chronic pain management*” means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

13.9(2) Interventional chronic pain management. The practice of interventional chronic pain management shall include the following:

- a.* Comprehensive assessment of the patient;
- b.* Diagnosis of the cause of the patient's pain;
- c.* Evaluation of alternative treatment options;
- d.* Selection of appropriate treatment options;
- e.* Termination of prescribed treatment options when appropriate;
- f.* Follow-up care; and
- g.* Collaboration with other health care providers.

13.9(3) Practice of medicine. Interventional chronic pain management is the practice of medicine.
[ARC 8918B, IAB 6/30/10, effective 8/4/10]

653—13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

13.10(1) Definition. As used in this rule:

“*Abortion-inducing drug*” means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

13.10(2) Physical examination required. A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination of the woman to determine, and document in the woman’s medical record, the gestational age and intrauterine location of the pregnancy.

13.10(3) Physician’s physical presence required. When inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided.

13.10(4) Follow-up appointment required. If an abortion is induced by an abortion-inducing drug, the physician inducing the abortion must schedule a follow-up appointment with the woman at the same facility where the abortion-inducing drug was provided, 12 to 18 days after the woman’s use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman’s medical condition. The physician shall use all reasonable efforts to ensure that the woman is aware of the follow-up appointment and that she returns for the appointment.

13.10(5) Parental notification regarding pregnant minors. A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L) adopted by the public health department.

[ARC 1034C, IAB 10/2/13, effective 11/6/13]

653—13.11(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

1. The board recognizes that technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.

2. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.

3. The board advises that licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.

4. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

13.11(1) Definitions. As used in this rule:

“*Asynchronous store-and-forward transmission*” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

“*Board*” means the Iowa board of medicine.

“*In-person encounter*” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

“*Licensee*” means a medical physician or osteopathic physician licensed by the board.

“*Telemedicine*” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an

audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

“*Telemedicine technologies*” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.11(2) *Practice guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.11(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.11(4) *Standards of care and professional ethics.* A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.11(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee’s scope of practice, including the licensee’s education, training, experience, ability, licensure, and certification.

13.11(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.11(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

- (1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;
- (2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient’s care; or
- (3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.11(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast

to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.11(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.11(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.11(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.11(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.11(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.11(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.11(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

- (1) Privacy;
- (2) Health care personnel who will process messages;
- (3) Hours of operation;
- (4) Types of transactions that will be permitted electronically;
- (5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;
- (6) Archiving and retrieval; and
- (7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.11(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies,

remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

a. The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act.

13.11(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.11(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.11(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.11(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

- c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;
- f. Emergency situations in which the life or health of the patient is in imminent danger;
- g. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;
- h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and
- i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.11(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.11(20).

13.11(22) *Medical abortion.* Nothing in this rule shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.
[ARC 1983C, IAB 4/29/15, effective 6/3/15]

653—13.12(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors in the name of an authorized facility.

13.12(1) Definitions. For purposes of this rule:

“Authorized facility” means any nonpublic school which is accredited pursuant to Iowa Code section 256.11, any school directly supported in whole or in part by taxation, a food establishment as defined in Iowa Code section 137F.1, a carnival as defined in Iowa Code section 88A.1, a recreational camp, a youth sports facility, or a sports area.

“Epinephrine auto-injector” means a device for immediate self-administration or administration by another trained person of a measured dose of epinephrine to a person at risk of anaphylaxis.

“Physician” means a person licensed pursuant to Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery.

13.12(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 280.16 and 280.16A.

13.12(3) A physician who prescribes epinephrine auto-injectors in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector.

[ARC 2387C, IAB 2/3/16, effective 3/9/16]

653—13.13(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

13.13(1) *Exemption from discipline.* To the extent consistent with state law, the board shall not revoke, fail to renew, suspend, or take any action against a physician's license based solely

on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

13.13(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

- a. The patient has a terminal illness, attested to by the patient's treating physician.
- b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).
- c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.
- d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.
- e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

13.13(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase I of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

13.13(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

13.13(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

- a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.
- b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.
- c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.
- d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description shall include the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device. The description shall be based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.
- e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.
- f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.
- g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

13.13(6) *Assisting suicide.* This rule shall not be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

13.13(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of rule 653—13.13(144E,147,148,272C) or 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.

b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.

c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

This rule is intended to implement Iowa Code chapters 144E, 147, 148 and 272C.
[ARC 3588C, IAB 1/17/18, effective 2/21/18]

653—13.14(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

13.14(1) *Exemption from discipline.* A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

a. The treatment is provided after an examination is performed and informed consent is received from the patient.

b. The physician identifies a medical reason for recommending or providing the treatment.

c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.

d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

13.14(2) *Lyme disease.* According to the Centers for Disease Control and Prevention (CDC), Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks, commonly known as deer ticks. Typical symptoms include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system. Lyme disease is diagnosed based on symptoms, physical findings (e.g., a rash), and the possibility of exposure to infected ticks. Laboratory testing is helpful if used correctly and performed with validated methods. Steps to prevent Lyme disease include using insect repellent, removing ticks promptly, applying pesticides, and reducing tick habitat. The ticks that transmit Lyme disease can occasionally transmit other tick-borne diseases as well.

13.14(3) *Lyme disease treatment.* Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

13.14(4) *Tick-borne diseases.* According to the CDC, tick-borne diseases include:

a. *Anaplasmosis* is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

b. *Babesiosis* is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged

tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.

c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.

d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.

e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.

f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.

g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis (Rickettsia phillipi)* is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

13.14(5) Grounds for discipline. A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.

b. The physician fails to identify and document a medical reason for recommending or providing the treatment.

c. The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.

d. The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.
[ARC 3589C, IAB 1/17/18, effective 2/21/18]

653—13.15(124E,147,148,272C) Standards of practice—medical cannabidiol.

13.15(1) Definitions. For purposes of this rule:

“*Board of medicine*” means the board established pursuant to Iowa Code chapters 147 and 148.

“*Bordering state*” means the same as defined in Iowa Code section 331.910.

“*Debilitating medical condition*” means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson's disease.
9. Untreatable pain.
10. Ulcerative colitis.
11. Severe, intractable pediatric autism with self-injurious or aggressive behaviors.
12. Corticobasal degeneration.

“*Department*” means the Iowa department of public health.

“*Form and quantity*” means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

“*Medical cannabidiol*” means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that has a tetrahydrocannabinol level of no more than 3 percent and that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

“*Medical cannabidiol board*” means the board established pursuant to Iowa Code section 124E.5.

“*Primary caregiver*” means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

“*Untreatable pain*” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“*Written certification*” means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the patient’s primary care provider which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

13.15(2) *Written certification.* A physician who is a patient’s primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician’s medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

13.15(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

13.15(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

13.15(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

13.15(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient’s possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

13.15(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual’s primary care provider.

b. The physician provides a patient a written certification without determining, in the physician’s medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

This rule is intended to implement Iowa Code chapters 124E, 147, 148 and 272C.
 [ARC 3830C, IAB 6/6/18, effective 7/11/18; ARC 4248C, IAB 1/16/19, effective 2/20/19; ARC 4377C, IAB 3/27/19, effective 5/1/19; ARC 4658C, IAB 9/11/19, effective 10/16/19]

653—13.16 to 13.19 Reserved.

653—13.20(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association shall be utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.20(1) Conflict of interest. A physician should not provide medical services under terms or conditions which tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.20(2) Fees. Any fee charged by a physician shall be reasonable.

653—13.21(17A,147,148,272C) Waiver prohibited. Rules in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.
 [ARC 5600C, IAB 5/5/21, effective 6/9/21]

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¹ Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

CHAPTER 17
LICENSURE OF ACUPUNCTURISTS

653—17.1(148E) Purpose. The licensure of acupuncturists is established to ensure that practitioners are qualified to provide Iowans with safe and healthful care. The provisions of Iowa Code chapters 147, 148E and 272C authorize the board of medicine to establish examination requirements for licensure; evaluate the credentials of applicants for licensure (147.2, 148E.3); grant licenses to qualified applicants (148E.2); institute continuing education requirements (272C.2); investigate complaints and reports alleging that licensed acupuncturists violated statutes and rules governing the practice of acupuncture (147.55, 148E.6); make available participation in the Iowa physician health program (272C.3); and discipline licensed acupuncturists found guilty of infractions as provided in state law and board rules (147.55, 148E.6).

653—17.2(148E) Scope of chapter. The rules in this chapter shall only apply to individuals licensed under Iowa Code chapter 148E. In accordance with Iowa Code section 148E.3, the rules in this chapter shall not apply to the following:

1. A person otherwise licensed by the state to practice medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatry, or dentistry who is exclusively engaged in the practice of the person's profession.

2. A student practicing acupuncture under the direct supervision of a licensed acupuncturist as part of a course of study approved by the board.

[ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.3(148E) Definitions.

"Accreditation Commission for Acupuncture and Oriental Medicine" or *"ACAOM"* means the United States-based accreditation commission that certifies acupuncture and oriental medicine training programs and colleges. The ACAOM oversees all professional oriental medicine and acupuncture degree programs in the United States. The ACAOM was formerly known as the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine.

"Acupuncture" means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

"Acupuncture needle" means a solid-core instrument including but not limited to acupuncture needles, dermal needles, intradermal needles, press tacks, plum blossom needles, prismatic needles, and disposable lancets.

"Acupuncture point" means a specific anatomical location on the human body that serves as the treatment site for the use of acupuncture.

"Applicant" means a person not otherwise authorized to practice acupuncture under Iowa Code section 148E.3 who applies to the board for a license.

"Ashi acupuncture point" means an acupuncture point that is located according to tenderness upon palpation. An *ashi* acupuncture point is also known as a trigger point.

"Board" means the board of medicine established in Iowa Code chapter 147.

"Committee" means the licensure committee of the board with oversight responsibility for administration of the licensure of acupuncturists.

"Department" means the Iowa department of public health.

"Disclosure sheet" means the written information licensed acupuncturists must provide to patients on initial contact.

"Disposable needles" means presterilized needles that are discarded after initial use pursuant to Iowa Code section 148E.5.

"License" means a license issued by the board pursuant to Iowa Code section 148E.2.

"Licensee" means a person holding a license to practice acupuncture issued by the board pursuant to Iowa Code chapter 148E.

“*National Certification Commission for Acupuncture and Oriental Medicine*” or “*NCCAOM*” means the United States-based commission that validates entry-level competency in the practice of acupuncture and oriental medicine through professional certification.

“*Practice of acupuncture*” means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medicine concepts.

“*Service charge*” means the amount charged by the board for making a service available online and is in addition to the actual fee for a service itself. For example, one who renews a license online will pay the license renewal fee and a service charge.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.4(147,148E) Eligibility for licensure.

17.4(1) Eligibility requirements. To be licensed to practice acupuncture by the board, a person shall meet all of the following requirements:

- a. Fulfill all the application requirements, as specified in 17.5(147,148E).
- b. Hold current active status as a diplomate in NCCAOM or, after June 1, 2004, hold current active status as a diplomate in acupuncture or oriental medicine from NCCAOM.
- c. Demonstrate sufficient knowledge of the English language to understand and be understood by patients and board and committee members.
 - (1) An applicant who passed the NCCAOM written and practical examination components in English may be presumed to have sufficient proficiency in English.
 - (2) An applicant who passed NCCAOM written or practical examination components in a language other than English shall pass the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examinations administered by the Educational Testing Service. A passing score on TSE is a minimum of 50. A passing score on TOEFL is a minimum overall score of 550 on the paper-based TOEFL that was administered on a Friday or Saturday (formerly special or international administration), a minimum overall score of 213 on the computer-administered TOEFL, or a minimum overall score of 79 on the Internet-based examination.
- d. Successfully complete a three-year postsecondary training program or acupuncture college program which is accredited by, in candidacy for accreditation by, or which meets the standards of the Accreditation Commission for Acupuncture and Oriental Medicine.
- e. Successfully complete a course in clean needle technique approved by the NCCAOM.

17.4(2) Waiver prohibited. Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—17.5(147,148E) Application requirements.

17.5(1) Application for licensure. To apply for a license to practice acupuncture, an applicant shall:

- a. Submit the completed application form provided by the board, including required credentials and documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;
- b. Pay the nonrefundable initial application fee identified in 653—paragraph 8.2(2) “a”; and
- c. Pay the fee identified in 653—paragraph 8.2(2) “e” for the evaluation of the fingerprint packet and the national criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

17.5(2) Contents of the application form. Each applicant shall submit the following information on the application form provided by the board:

- a. The applicant’s full legal name, date and place of birth, home address, mailing address, principal business address, and personal e-mail address regularly used by the applicant or licensee for correspondence with the board;
- b. A photograph of the applicant suitable for positive identification;

- c.* A chronology accounting for all time periods from the date the applicant entered an acupuncture and oriental medicine training program or college to the date of the application;
- d.* The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice acupuncture, including license, certificate of registration or certification numbers, and date of issuance;
- e.* Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process;
- f.* A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;
- g.* A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;
- h.* The NCCAOM score report verification form submitted directly to the board by the NCCAOM;
- i.* An NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM;
- j.* Proof of successful completion of a course in clean needle technique approved by the NCCAOM;
- k.* A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in the practice of acupuncture and provide patients with safe and healthful care;
- l.* A description of the applicant's clinical acupuncture training, work experience and, where applicable, supporting documentation;
- m.* A copy of the applicant's acupuncture degree issued by an educational institution. If a copy of the acupuncture degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;
- n.* A complete translation of any diploma not written in English. An official transcript, written in English and received directly from the educational institution, showing graduation from an acupuncture training program or an educational institution is a suitable alternative;
- o.* A sworn statement from an official of the educational institution certifying the date the applicant received the acupuncture degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;
- p.* An official transcript sent directly from an acupuncture training program or an educational institution attended by the applicant and, if requested by the board, an English translation of the official transcript;
- q.* Proof of the applicant's proficiency in the English language, when the applicant has not passed the English version of the NCCAOM written and practical examinations;
- r.* Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board; and
- s.* A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

17.5(3) *Disclosure sheet.* Rescinded IAB 2/15/17, effective 3/22/17.

17.5(4) *Application cycle.* If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—paragraph 8.2(2)“b” and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, applicants must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

17.5(5) Applicant responsibilities. An applicant for licensure to practice acupuncture bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national testing or credentialing organizations, health facilities, and educational institutions providing the information specified in 17.5(2);

b. Providing accurate, up-to-date, and truthful information on the application form including, but not limited to, that specified under 17.5(2) related to prior professional experience, education, training, examination scores, diplomate status, licensure or registration, and disciplinary history; and

c. Submitting English translations of documents in foreign languages bearing the affidavit of the translator certifying that the translation is a true and complete translation of the foreign language original. The applicant shall bear the expense of the translation.

17.5(6) Licensure application review process. The process below shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff shall notify the applicant about how to resolve any problems identified by the reviewer. An applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant’s qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant’s current qualifications for licensure.

(1) If there is no current concern, staff shall administratively grant the license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters which include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:

1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

2. Successfully pass a competency evaluation approved by the board;

3. Successfully pass an examination approved by the board; or

4. Successfully complete a reentry to practice program or monitoring program approved by the board;

- (4) Issue a license;
- (5) Issue a license under certain terms and conditions or with certain restrictions;
- (6) Request that the applicant withdraw the licensure application; or
- (7) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Request an investigation;
- (2) Request that the applicant appear for an interview;
- (3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:

1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

2. Successfully pass a competency evaluation approved by the board;

3. Successfully pass an examination approved by the board; or

4. Successfully complete a reentry to practice program or monitoring program approved by the board;

- (4) Issue a license;

- (5) Issue a license under certain terms and conditions or with certain restrictions;

- (6) Request that the applicant withdraw the licensure application; or

- (7) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

17.5(7) *Grounds for denial of licensure.* The board, on the recommendation of the committee, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in rule 653—17.4(147,148E) as authorized by Iowa Code section 148E.2 or of this chapter of the board's rules.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148E.8 or in rule 653—17.12(147,148E,272C).

17.5(8) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

17.5(9) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

17.5(10) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with 653—25.30(17A).

a. License denial hearings are contested cases open to the public.

b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

c. Evidence supporting the denial of the license may be presented by an assistant attorney general.

d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions, or deny the license. The final decision is a public record.

f. Judicial review of a final order of the board denying licensure, or issuing a license with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

17.5(11) Finality. If an applicant does not appeal a preliminary notice of denial in accordance with 17.5(9), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

17.5(12) Failure to pursue appeal. If an applicant appeals a preliminary notice of denial in accordance with 17.5(9) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

17.5(13) Waiver prohibited. Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—17.6(147,148E) Display of license and disclosure of information to patients.

17.6(1) Display of license. Licensed acupuncturists shall display the license issued by the board in a conspicuous place in their primary place of business.

17.6(2) Distribution and retention of disclosure sheet. Pursuant to Iowa Code section 148E.6, the licensee shall distribute a disclosure sheet on initial contact with patients and retain a copy, signed and dated by the patient, for a period of at least five years after termination of treatment. The disclosure sheet shall include the following:

- a.* The name, business address, and business telephone number of the acupuncturist.
- b.* A fee schedule.
- c.* A listing of the acupuncturist's education, experience, degrees, certificates, or credentials related to acupuncture awarded by professional acupuncture organizations and the length of time required to obtain the degrees or credentials and experience.
- d.* A statement indicating any license, certificate, or registration in a health care occupation that was revoked by any local, state, or national health care agency.
- e.* A statement that the acupuncturist is complying with statutes and rules adopted by the board, including a statement that only presterilized, disposable needles are used by the acupuncturist.
- f.* A statement indicating that the practice of acupuncture is regulated by the board.
- g.* A statement indicating that a license to practice acupuncture does not authorize a person to practice medicine and surgery in this state and that the services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice.

[ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.7(147,148E,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148E.2, a license expires on October 31 of even-numbered years and can be renewed for the fee identified in 653—paragraph 8.2(2)“c.” The applicant for renewal shall provide an NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

17.7(1) Expiration date. Certificates of licensure to practice acupuncture shall expire on October 31 in even years.

17.7(2) Prorated fees. The first renewal fee for a license shall be prorated on a monthly basis according to the date of issue.

17.7(3) Renewal requirements and penalties for late renewal. Each licensee shall be sent a renewal notice at least 60 days prior to the expiration date. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

a. When online renewal is used, the licensee must complete the online renewal prior to midnight on December 31 in order to ensure that the license will not become inactive. The license becomes inactive and invalid at 12:01 a.m. on January 1.

b. Upon receipt of the completed renewal application, staff shall administratively issue a license that expires on October 31 of even-numbered years. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration.

c. Every renewal shall be displayed in connection with the original certificate of licensure.

d. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a \$50 penalty shall be assessed for renewal in the grace period, a period up until January 1 when the license becomes inactive if not renewed.

17.7(4) Inactive license. Failure of a licensee to renew by January 1 will result in invalidation of the license and the license will become inactive.

a. Licensees are prohibited from engaging in the practice of acupuncture once the license is lapsed.

b. Having an acupuncturist license in lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148E.8.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.8(147,272C) Reinstatement of an inactive license.

17.8(1) Reinstatement requirements. Licensees who allow their licenses to go inactive by failing to renew may apply for reinstatement of a license. Pursuant to Iowa Code section 147.11, applicants for reinstatement shall:

a. Submit upon forms provided by the board a completed application for reinstatement of a license to practice acupuncture. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal e-mail address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

(5) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provided patients with safe and healthful care.

(6) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(7) A chronology accounting for all time periods from the date of initial licensure.

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—paragraph 8.2(2)“*e*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reinstatement fee of \$400 plus the fee identified in 653—paragraph 8.2(2)“*e*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. Provide an NCCAOM certificate which demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

e. Meet any new requirements instituted since the license lapsed.

17.8(2) Reinstatement restrictions. Pursuant to Iowa Code section 272C.3(2)“*d*,” the committee may require an applicant who has not engaged in active practice in the past three years in any jurisdiction of the United States to meet any or all of the following requirements prior to reinstatement of an inactive license:

a. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

b. Successfully pass a competency evaluation approved by the board;

c. Successfully pass an examination approved by the board; or

d. Successfully complete a reentry to practice program or monitoring program approved by the board.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.9(272C) Continuing education requirements. Licensees shall demonstrate that they hold current active status as a diplomate from the NCCAOM. The NCCAOM requires 60 points of professional development activity every four years. Active NCCAOM certification satisfies the continuing education requirements established in Iowa Code section 272C.2.

[ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.10(147,148E,272C) General provisions.

17.10(1) Diagnostic and treatment modalities. Diagnostic and treatment modalities used by licensees under this chapter may include one or more of the following acupunctural services:

a. The stimulation or piercing of the skin with an acupuncture needle for any of the following purposes:

(1) To evoke a therapeutic physiological response, either locally or distally to the area of insertion or stimulation.

(2) To relieve pain or treat the neuromusculoskeletal system.

(3) To stimulate ashi acupuncture points to relieve pain and dysfunction.

(4) To promote, maintain, and restore health and to prevent disease.

(5) To stimulate the body according to auricular, hand, nose, face, foot or scalp acupuncture therapy.

(6) To use acupuncture needles with or without the use of herbs, electric current, or application of heat.

b. The use of oriental medical diagnosis and treatment, including:

(1) Moxibustion, cupping, thermal methods, magnets, gua sha scraping techniques, acupatches, herbal poultices, hot and cold packs, electromagnetic wave therapy, light and color therapy, sound therapy, or therapy lasers.

(2) Massage, acupressure, reflexology, shiatsu and tui na massage, or manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin.

(3) Herbal medicine and dietary supplements, including those of plant, mineral, animal, and nutraceutical origin.

c. Any other adjunctive service or procedure that is clinically appropriate based on the licensee’s training as approved by NCCAOM or ACAOM.

17.10(2) Use and disposal of needles. A licensee shall use only presterilized, disposable needles and shall provide for the disposal of used needles in accordance with the requirements of the department.

17.10(3) Standard of care. A licensee shall be held to the same standard of care as persons licensed to practice medicine and surgery or osteopathic medicine and surgery. Pursuant to Iowa Code section

272C.3, any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care in the practice of acupuncture constitutes malpractice and is grounds for the revocation or suspension of a license to practice acupuncture in this state.

17.10(4) Title. An acupuncturist licensed under this title may use the words “licensed acupuncturist” or “L.Ac.” to connote professional standing after the licensee’s name in accordance with Iowa Code section 147.74(18).

17.10(5) Change of contact information. Licensees shall notify the board of changes in home address, address of the place of practice, home or practice telephone number, or personal e-mail address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

17.10(6) Delegation of responsibilities. A licensee shall perform all aspects of acupuncture treatment that involve penetration of the skin of a patient. The licensee may delegate other aspects of treatment to staff and patients who are properly trained by the licensee. It is permissible for appropriately trained staff and patients to remove acupuncture needles from the patient’s body. The licensee is responsible for establishing and maintaining written training standards for staff.

17.10(7) Change of full legal name. A licensee shall notify the board of any change in the licensee’s full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

17.10(8) Deceased. A licensee’s file shall be closed and labeled “deceased” when the board receives a copy of the licensee’s death certificate or other reliable information of the licensee’s death.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.11(147,148E,272C) General disciplinary provisions. The board is authorized to take disciplinary action against any licensee who violates the provisions set forth in state law and administrative rules pertaining to the safe and healthful practice of acupuncture. This rule is not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

17.11(1) Methods of discipline. The board may impose any of the following disciplinary sanctions:

- a. Revocation of a license;
- b. Suspension of a license until further order of the board;
- c. Nonrenewal of a license;
- d. Restrict permanently or temporarily the performance of specific procedures, methods, acts or techniques;
- e. Probation;
- f. Additional or remedial education or training;
- g. Reexamination;
- h. Medical or physical evaluation, or alcohol or drug screening within a specific time frame at a facility or by a practitioner of the board’s choice;
- i. Civil penalties not to exceed \$1,000;
- j. Citations and warnings as necessary; and
- k. Other sanctions allowed by law as deemed appropriate.

17.11(2) Discretion of the board. The board may consider the following factors when determining the nature and severity of the disciplinary sanction to be imposed:

- a. The relative seriousness of the violation as it relates to assuring the citizens of Iowa a high standard of professional care.
- b. The facts of the particular violation.
- c. Any extenuating circumstances or other countervailing considerations.
- d. Number of prior violations or complaints.
- e. Seriousness of prior violations or complaints.
- f. Whether remedial action has been taken.
- g. Such other factors as may reflect upon the competency, ethical standards and professional conduct of the licensee.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—17.12(147,148E,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions set forth in 17.11(1) upon determining that a licensee is guilty of any of the following acts or offenses:

17.12(1) *Fraud in procuring a license.* Fraud in procuring a license is the deliberate distortion of facts or use of deceptive tactics in the application for licensure to practice acupuncture including, but not limited to:

- a. Making false or misleading statements in obtaining or seeking to obtain licensure;
- b. Failing to disclose by deliberate omission or concealment any information the board deems relevant to the safe and healthful practice of acupuncture pursuant to Iowa Code chapters 147 and 148E;
- c. Misrepresenting any fact or deed to meet the application or eligibility requirements established by this chapter; or
- d. Filing or attempting to file a false, forged or altered diploma, certificate, affidavit, translated or other official or certified document, including the application form, attesting to the applicant's eligibility for licensure to practice acupuncture in Iowa.

17.12(2) *Professional incompetence.* Professional incompetence includes, but is not limited to:

- a. Substantial lack of knowledge or ability to discharge professional obligations within the scope of the acupuncturist's practice;
- b. Substantial deviation by the licensee from the standards of learning or skill ordinarily possessed and applied by other acupuncturists when acting in the same or similar circumstances;
- c. Failure by an acupuncturist to exercise in a substantial respect the degree of care which is ordinarily exercised by the average acupuncturist when acting in the same or similar circumstances; or
- d. Willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of acupuncture.

17.12(3) *Fraud in the practice of acupuncture.* Fraud in the practice of acupuncture includes, but is not limited to, any misleading, deceptive, untrue or fraudulent representation in the practice of acupuncture, made orally or in writing, that is contrary to the acupuncturist's legal or equitable duty, trust or confidence and is deemed by the board to be contrary to good conscience, prejudicial to the public welfare, and potentially injurious to another. Proof of actual injury need not be established.

17.12(4) *Unethical conduct.* The Code of Ethics (2008) prepared and approved by the NCCAOM shall be utilized by the board as guiding principles in the practice of acupuncture in this state. Unethical conduct in the practice of acupuncture includes, but is not limited to:

- a. Failing to provide patients with the information required in Iowa Code section 148E.6 or providing false information to patients;
- b. Accepting remuneration for referral of patients to other health care professionals;
- c. Offering or providing remuneration for the referral of patients, excluding paid advertisements or marketing services;
- d. Engaging in sexual activity or genital contact with a patient while acting or purporting to act within the scope of the acupuncture practice, whether or not the patient consented to the sexual activity or genital contact;
- e. Disclosing confidential information about a patient without proper authorization; or
- f. Abrogating the boundaries of acceptable conduct in the practice of acupuncture established by the profession that the board deems appropriate for ensuring that acupuncturists provide Iowans with safe and healthful care.

17.12(5) *Practice harmful to the public.* Practice harmful or detrimental to the public in the practice of acupuncture includes, but is not limited to:

- a. Failing to possess and exercise the degree of skill, learning and care expected of a reasonable, prudent acupuncturist acting in the same or similar circumstances;
- b. Practicing acupuncture without reasonable skill and safety as the result of a mental or physical impairment, chemical abuse or chemical dependency;
- c. Prescribing, dispensing or administering any controlled substance or prescription medication for human use; or

d. Performing any treatment or healing procedure not authorized in Iowa Code chapter 148E or this chapter.

17.12(6) *Habitual intoxication or addiction.* Habitual intoxication or addiction to the use of drugs includes, but is not limited to, the inability to practice acupuncture with reasonable skill and safety as a result of the excessive use of alcohol, drugs, narcotics, chemicals or other substances on a continuing basis, or the excessive use of the same in a way which may impair the ability to practice acupuncture with reasonable skill and safety.

17.12(7) *Felony conviction.* A felony conviction related to the practice of acupuncture or that affects the ability to practice the profession includes, but is not limited to:

a. Any conviction for any public offense directly related to or associated with the practice of acupuncture that is classified as a felony under the statutes of any jurisdiction of the United States, the United States government, or another nation or its political subdivisions; or

b. Any conviction for a public offense affecting the ability to practice acupuncture that is classified as a felony under the statutes of any jurisdiction of the United States, the United States government, or another nation or its political subdivisions and that involves moral turpitude, civility, honesty, or morals.

A copy of the record of conviction or plea of guilty or nolo contendere shall be conclusive evidence of the felony conviction.

17.12(8) *Misrepresentation of scope of practice by licensees.* Misrepresentation of a licensee's scope of practice includes, but is not limited to, misleading, deceptive or untrue representations about competency, education, training or skill as a licensed acupuncturist or the ability to perform services not authorized under this chapter.

17.12(9) *False advertising.* False advertising is the use of fraudulent, deceptive or improbable statements in information provided to the public. False advertising includes, but is not limited to:

a. Unsubstantiated claims about the licensee's skills or abilities, the healing properties of acupuncture or specific techniques or treatments therein;

b. Presenting words, phrases, or figures which are misleading or likely to be misunderstood by the average person; or

c. Claiming extraordinary skills that are not recognized by the acupuncture profession.

17.12(10) *General grounds.* The board may also take disciplinary action against an acupuncturist for any of the following reasons:

a. Failure to comply with the provisions of Iowa Code chapter 148E or the applicable provisions of Iowa Code chapter 147, or the failure of an acupuncturist to comply with rules adopted by the board pursuant to Iowa Code chapter 148E;

b. Failure to notify the board of any adverse judgment or settlement of a malpractice claim or action within 30 days of the date of the judgment or settlement;

c. Failure to report to the board any acts or omissions of another acupuncturist authorized to practice in Iowa that would constitute grounds for discipline under 653—17.12(147,148E,272C) within 30 days of the date the acupuncturist initially became aware of the information;

d. Failure to comply with a subpoena issued by the board;

e. Failure to adhere to the disciplinary sanctions imposed upon the acupuncturist by the board; or

f. Violating any of the grounds for revocation or suspension of licensure listed in Iowa Code chapter 147 or 148E.

[ARC 8707B, IAB 5/5/10, effective 6/9/10; ARC 2950C, IAB 2/15/17, effective 3/22/17]

653—17.13(272C) Procedure for peer review. Rule 653—24.3(272C) shall apply to peer review procedures in matters related to licensed acupuncturists.

653—17.14(272C) Reporting duties and investigation of reports. 653—Chapters 22 and 24 shall apply to certain reporting responsibilities of licensed acupuncturists and the investigation of malpractice cases involving licensed acupuncturists.

653—17.15(272C) Complaints, immunities and privileged communications. 653—Chapter 24 shall apply to matters relating to licensed acupuncturists.

653—17.16(272C) Confidentiality of investigative files. 653—subrule 24.9(2) shall apply to investigative files relating to licensed acupuncturists.

653—17.17 to 17.28 Reserved.

653—17.29(17A,147,148E,272C) Disciplinary procedures. 653—Chapter 25 shall apply to disciplinary actions against licensed acupuncturists.

653—17.30(147,148E,272C) Waiver prohibited. Fees in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapter 148E and sections 17A.10 to 17A.20, 147.55, 272C.3 to 272C.6, 272C.8 and 272C.9.

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[◊] Two or more ARCs

CHAPTER 19
PRESCRIBING PSYCHOLOGISTS

653—19.1(148,154B) Definitions—joint rule.

“*APA*” means the American Psychological Association.

“*Applicant*” means a psychologist applying for a conditional prescription certificate.

“*Board*” means the Iowa board of psychology.

“*Board of medicine*” means the Iowa board of medicine.

“*Collaborating physician*” means a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician’s normal course of practice, and who serves as a resource for a prescribing psychologist pursuant to a collaborative practice agreement. A collaborating physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry.

“*Conditional prescribing psychologist*” means a person licensed to practice psychology in Iowa who holds an active conditional prescription certificate. This term does not include prescribing psychologists.

“*Conditional prescription certificate*” means a certificate issued by the board to a psychologist that permits the psychologist to prescribe psychotropic medication under the supervision of a supervising physician.

“*CSA registration*” means a Controlled Substance Act registration issued by the Iowa board of pharmacy authorizing a psychologist to possess and prescribe controlled substances.

“*DEA registration*” means a mid-level practitioner registration with the Drug Enforcement Administration authorizing a psychologist to possess and prescribe controlled substances.

“*Joint rule*” means a rule adopted by agreement of the board of psychology and the board of medicine through the joint rule-making process.

“*Mental disorder*” means a disorder which is defined by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or contained within the mental and behavioral disorders chapter of the most recent version of the International Classification of Diseases.

“*Prescribing psychologist*” means a person licensed to practice psychology in Iowa who holds an active prescription certificate. This term does not include conditional prescribing psychologists.

“*Prescription certificate*” means a certificate issued by the board to a psychologist that permits the psychologist to prescribe psychotropic medication.

“*Primary care physician*” means a person licensed to practice medicine and surgery or osteopathic medicine in Iowa who is responsible for the ongoing medical care of a patient.

“*Psychologist*” means a person licensed to practice psychology in Iowa.

“*Psychotropic medication*” means a medication that shall not be dispensed or administered without a prescription and that has been explicitly approved by the federal Food and Drug Administration for the treatment of a mental disorder, as defined by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the most recent version of the International Classification of Diseases. “Psychotropic medication” does not include narcotics.

“*Supervising physician*” means a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician’s normal course of practice, and who supervises a conditional prescribing psychologist. A supervising physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry.

“*Training director*” means an employee of the psychopharmacology training program who is primarily responsible for directing the training program.

“*Training physician*” means a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician’s normal course of practice, and who provides training to a psychologist as part of the clinical experience and practicum described in rule 653—19.2(148,154B). A

training physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A training physician shall be approved by the psychopharmacology training program.
[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.2(148,154B) Educational requirements for conditional prescription certificate—joint rule. An applicant for a conditional prescription certificate shall have completed a program of study designated by the APA as a program for the psychopharmacology training of postdoctoral psychologists. The program must have included didactic instruction, a clinical experience, and a practicum satisfying the requirements of this rule. A minimum of 40 hours of basic training on clinical assessment skills shall be included as part of the program's didactic instruction.

19.2(1) Degree. An applicant shall possess a postdoctoral master of science degree in clinical psychopharmacology from a program designated by the APA as a program for the psychopharmacology training of postdoctoral psychologists. The degree program must be a minimum of 30 credit hours not including the practicum and shall include coursework in basic science, neuroscience, clinical medicine, pathological basis of disease, clinical pharmacology, psychopharmacology, and professional, ethical and legal issues. A minimum of one-third of the coursework must be completed in a live interactive format. The date the degree is conferred must be within the five-year period immediately preceding the application for a conditional prescription certificate. A program must be designated by the APA at the time the degree is conferred.

19.2(2) Clinical experience. An applicant shall have completed a clinical experience in accordance with the requirements of this subrule. During the clinical experience, a psychologist shall learn clinical assessment techniques and pathophysiology through direct observation and hands-on training with a training physician. During the clinical experience, a psychologist shall become competent in health history interviews, physical examinations, and neurological examinations with a medically diverse patient population. The clinical experience must be associated with the psychopharmacology training program from which the psychologist obtained the postdoctoral master of science degree in clinical psychopharmacology.

a. Scope. At the beginning of the clinical experience, the psychologist shall directly observe the training physician performing clinical assessments of patients. After the training physician determines the psychologist has gained sufficient knowledge, the clinical experience shall transition to the psychologist's performance of clinical assessments of patients under the direct observation of the training physician. After the training physician determines the psychologist has gained sufficient knowledge and experience, the psychologist may perform clinical assessments of patients without being directly observed by the training physician, provided that the training physician is on site at all times when the psychologist is with patients and is reviewing all medical records. A psychologist and a training physician shall have ongoing discussions regarding the psychologist's clinical assessment skills and progress in the clinical experience.

b. Minimum experience. The clinical experience shall consist of a minimum of 600 patient encounters that shall be completed by the end of the practicum.

c. Conflict of interest. A training physician shall not be an employee of the psychologist or otherwise have a conflict of interest that could affect the training physician's ability to impartially evaluate the psychologist's performance. A psychologist may utilize more than one training physician.

d. Milestones. To satisfactorily complete the clinical experience, a psychologist shall demonstrate competency in each of the following:

(1) Perform a health history interview to obtain pertinent information regarding a patient's chief complaint, history of the present illness, past medical and surgical history, family history, allergies, medications, and psychosocial history. The psychologist shall perform a review of systems to elicit a health history and shall appropriately document the health history.

(2) Perform a physical examination in a logical sequence, ensuring appropriate positioning of the patient, proper patient draping, and proper application of the principles of asepsis throughout the examination. The psychologist shall verbalize and assess the components of a general survey and be able to accurately assess all of the following: vital signs, including pulse, respiration, and blood

pressure; skin, hair and nails; head, face and neck; eyes; ears, nose, mouth and throat; thorax, lungs and axillae; heart; peripheral vascular system; abdomen; and musculoskeletal system. The psychologist shall be proficient in utilizing any equipment needed to conduct a physical examination.

(3) Complete a neurological examination demonstrating knowledge of the history related to the neurological system and the ability to assess the following: mental status, cranial nerves, motor system, sensory system, and reflexes. The psychologist shall differentiate normal laboratory values from abnormal laboratory values and correlate abnormal laboratory values with impaired physiological systems. The psychologist shall identify adverse drug reactions and identify laboratory data and physical signs indicating an adverse drug reaction.

e. Informed consent. At the initial contact, the psychologist shall inform the patient, or the patient's legal guardian when appropriate, of the psychologist's training role in the clinical experience. The psychologist shall provide sufficient information regarding the expectations and requirements of the clinical experience to obtain informed consent and appropriate releases. Upon request, the psychologist shall provide additional information regarding the psychologist's education, training, or experience.

f. Training documentation. The psychologist and the training director shall maintain documentation accounting for all clinical experience patient encounters, including the dates, times, and locations of all clinical experience patient encounters, and documentation of completion of the milestones defined in these rules. The applicant shall provide additional documentation to the board upon request.

g. Certification. The training physician(s) and the training director shall certify on forms provided by the board that the applicant has successfully completed the minimum number of clinical experience patient encounters required and demonstrated competence in clinical assessment techniques and pathophysiology through completion of the milestones defined in these rules.

19.2(3) Practicum. An applicant shall have completed a practicum in accordance with the requirements of this subrule. During the practicum, a psychologist shall develop competencies in evaluating and treating patients with mental disorders through pharmacological intervention via observation and active participation. The practicum must be associated with the psychopharmacology training program from which the applicant obtained the postdoctoral master of science degree in clinical psychopharmacology and must be completed in a period of time not less than six months and not more than three years.

a. Scope. At the beginning of the practicum, the psychologist shall directly observe the training physician evaluating and treating patients with mental disorders. After the training physician determines the psychologist has gained sufficient knowledge, the practicum shall transition to the psychologist's evaluation and treatment of patients under the direct observation of the training physician. After the training physician determines the psychologist has gained sufficient knowledge and experience, the psychologist may evaluate and treat patients without being directly observed by the training physician, provided that the training physician is on site at all times when the psychologist is with patients, has personal contact with the patient at each visit, and is reviewing all pertinent medical records. During the practicum, the training physician shall make all final treatment decisions, with consultation from the psychologist prior to making a final determination regarding the psychopharmacological treatment of a patient.

b. Minimum number of hours. A practicum shall consist of a minimum of 400 hours. Only hours spent face to face evaluating and treating patients with mental disorders and hours spent discussing treatment plans with a training physician may count as practicum hours. Time spent by the psychologist providing services that are within the scope of practice of a licensed psychologist, such as psychological examinations and psychotherapy, shall not be counted as practicum hours.

c. Minimum number of patients. A psychologist shall see a minimum of 100 individual patients throughout the practicum. A patient can be counted toward this requirement if the patient has a diagnosed mental disorder and pharmacological intervention is considered as a treatment option, even if a decision is made not to prescribe a psychotropic medication to the patient. Over the course of the practicum, the psychologist shall observe, evaluate, and treat patients encompassing a range of ages and a variety of psychiatric diagnoses.

d. Settings. At least 100 hours of the 400 hours must be completed in a psychiatric setting. At least 100 hours of the 400 hours must be completed in a primary care or community mental health setting.

e. Conflict of interest. A training physician shall not be an employee of the psychologist or otherwise have a conflict of interest that could affect the training physician's ability to impartially evaluate the psychologist's performance. A psychologist may utilize more than one training physician.

f. Milestones. To successfully complete the practicum, a psychologist shall demonstrate competency in each of the following:

(1) Physical examination and mental status examination. The psychologist shall perform comprehensive and focused physical examinations and mental status evaluations, demonstrate proper use of instruments, and recognize variation associated with developmental stages and diversity.

(2) Review of systems. The psychologist shall integrate information learned from patient reports, signs, symptoms, and a review of each major body system, recognizing normal developmental variations.

(3) Medical history interview. The psychologist shall systematically conduct a patient clinical interview, producing a patient's medical, surgical, psychiatric, and medication history, as well as a family medical and psychiatric history, and be able to communicate the findings in written and verbal form.

(4) Assessment indications and interpretation. The psychologist shall order and interpret appropriate tests (e.g., psychometric, laboratory, and radiological) for the purpose of making a differential diagnosis and monitoring therapeutic and adverse effects of treatment.

(5) Differential diagnosis. The psychologist shall determine primary and alternate diagnoses using established diagnostic criteria.

(6) Integrated treatment planning. The psychologist shall identify and select, using all available data, the most appropriate treatment alternatives, including medication, psychosocial, and combined treatments, and sequence treatment within the larger biopsychosocial context.

(7) Consultation and collaboration. The psychologist shall understand the parameters of the role of a prescribing psychologist and work with other professionals, including a patient's primary care physician, in an advisory or collaborative manner to effectively treat a patient.

(8) Treatment management. The psychologist shall apply, monitor, and modify as needed the treatment of a patient and learn to write valid and complete prescriptions.

(9) Medical documentation. The psychologist shall demonstrate appropriate medical documentation for the patient-psychologist interaction to include subjective and objective assessment; mental status, physical examination findings, or both; formulation; diagnostic impression; and comprehensive treatment plan.

g. Informed consent. At the initial contact, the psychologist shall inform the patient, or the patient's legal guardian when appropriate, of the psychologist's training role in the practicum. The psychologist shall provide sufficient information regarding the expectations and requirements of the practicum to obtain informed consent and appropriate releases. Upon request, the psychologist shall provide additional information regarding the psychologist's education, training, or experience.

h. Training documentation. The psychologist and the training director shall maintain documentation regarding all patients observed, evaluated, and treated by the psychologist as part of the practicum. The documentation shall clearly identify the training physician for each patient. The psychologist and the training director shall maintain documentation of all practicum hours, including the dates, times, and locations of all practicum hours, and documentation of completion of the milestones defined in these rules. The applicant shall provide additional documentation to the board upon request.

i. Certification. The training physician(s) and the training director shall certify on forms provided by the board that the psychologist has successfully completed the minimum number of practicum hours, treated the minimum number of patients, and demonstrated competence in the evaluation and treatment of patients with mental disorders through pharmacological intervention through completion of the milestones defined in these rules.

19.2(4) Examination. A psychologist shall pass the Psychopharmacology Examination for Psychologists (PEP) administered by the APA Practice Organization's College of Professional Psychology or by the Association of State and Provincial Psychology Boards. The passing score utilized

by the board shall be the passing score recommended by the test administrator. The examination score shall be sent directly from the testing service to the board.

[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.3(148,154B) Supervised practice as a conditional prescribing psychologist—joint rule. A conditional prescribing psychologist shall complete a minimum of two years of supervised practice in prescribing psychotropic medications to patients with mental disorders in accordance with this rule to be eligible to apply for a prescription certificate.

19.3(1) Supervision plan. Prior to issuing a conditional prescription certificate, the board shall review and approve the proposed supervision plan.

a. The proposed supervision plan must include the following:

(1) Conditional prescribing psychologist information. The plan must include the name, license number, address, telephone number, and email address of the supervisee.

(2) Supervising physician information. The plan must include the name, license number, date of licensure, area of specialization, address, telephone number, and email address of each supervising physician.

(3) Primary supervising physician. The plan must include a designation of the primary supervising physician.

(4) Period of supervision. The plan must include the beginning date of the supervision plan and estimated date of completion.

(5) Locations and settings. The plan must include a description of the locations and settings where and with whom supervision will occur.

(6) Scope of practice. The plan must include a description of the scope of practice of the conditional prescribing psychologist, including any limitations on the types of psychotropic medications that may be prescribed and the patient populations to which a prescription may be issued and including the expectations and responsibilities of the supervising physician.

(7) Release of information. The plan must include a provision requiring the conditional prescribing psychologist to obtain a release of information from all patients who are considered for psychopharmacological intervention, authorizing the conditional prescribing psychologist to share the patient's health information with the supervising physician.

(8) Consultation between the conditional prescribing psychologist and the supervising physician. The plan must include a provision requiring that the conditional prescribing psychologist consult with the supervising physician on a regular basis regarding a patient's psychotropic treatment plan and any potential complications. A conditional prescribing psychologist shall not prescribe a new psychotropic medication, discontinue a psychotropic medication, or change the dosage of a psychotropic medication if the supervising physician objects on the basis of a contraindication.

(9) Consultation between the supervising physician and the primary care physician. The plan must include a provision requiring that the supervising physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

(10) Termination of the supervision plan. The plan must include a description of how the supervision plan may be terminated and the process for notifying affected patients.

(11) Signatures. The plan must include signatures of the psychologist and all supervising physicians.

b. A conditional prescribing psychologist shall inform the board of any amendments to the conditional prescribing psychologist's supervision plan, including the addition of any supervising physicians, within 30 days of the change. Amendments to a supervision plan are subject to board approval.

c. The board shall transmit all approved supervision plans and approved amendments to the board of medicine.

19.3(2) Responsibilities of a supervising physician. A supervising physician shall provide supervision in accordance with rules established by the board of medicine.

19.3(3) Responsibilities of a conditional prescribing psychologist. At the initial contact, a conditional prescribing psychologist shall inform a patient, or a patient's legal guardian when appropriate, that the conditional prescribing psychologist is practicing under the supervision of a physician for purposes of prescribing psychotropic medication and shall provide the name of the supervising physician. A conditional prescribing psychologist shall provide sufficient information regarding the supervision requirements to obtain informed consent and appropriate releases. Upon request, a conditional prescribing psychologist shall provide additional information regarding the conditional prescribing psychologist's education, training, or experience with respect to prescribing psychotropic medications.

19.3(4) Specialization. A conditional prescribing psychologist shall complete the following training during the supervised practice period to be eligible to prescribe psychotropic medications to the respective population as a prescribing psychologist:

a. Children. To prescribe to patients who are less than 17 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A pediatric practice,
- (2) A child and adolescent practice, or
- (3) A general practice provided the conditional prescribing psychologist treats a minimum of 50 patients who are less than 17 years of age.

b. Elderly patients. To prescribe to patients who are over 65 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A geriatric practice, or
- (2) A general practice with patients across the lifespan including patients who are over 65 years of age.

c. Serious medical conditions. To prescribe to patients with serious medical conditions including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, a conditional prescribing psychologist shall complete at least one year prescribing psychotropic medications to patients with serious medical conditions.

19.3(5) Completion of supervised practice. A conditional prescribing psychologist shall see a minimum of 300 patients over a minimum of two years to complete the supervised practice period, provided each of the 300 patients has a diagnosed mental disorder and pharmacological intervention is considered as a treatment option, even if a decision is made not to prescribe a psychotropic medication to the patient. A conditional prescribing psychologist shall treat a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

a. At the conclusion of the supervised practice period, a primary supervising physician shall certify the following:

- (1) Supervision was provided in accordance with rules established by the board of medicine.
- (2) A conditional prescribing psychologist has successfully completed two years of supervised practice, considered at least 300 patients for psychopharmacological intervention, and treated at least 100 patients with psychotropic medications.
- (3) A conditional prescribing psychologist intending to specialize in the psychological care of children or elderly persons, or persons with serious medical conditions, has completed the requirements of subrule 19.3(4).

(4) A conditional prescribing psychologist has successfully completed the supervised practice period and demonstrated competence in psychopharmacology by demonstrating competency in the milestones listed in paragraph 19.2(3) "f" sufficient to obtain a prescription certificate.

b. If a conditional prescribing psychologist is unable to successfully complete the supervised practice period prior to the expiration of the conditional prescription certificate, the conditional prescribing psychologist may request an extension of the conditional prescription certificate provided that the conditional prescribing psychologist can demonstrate that the conditional prescribing psychologist is likely to successfully complete the supervised practice within the extended time

requested. Any requests for extension must be submitted to and approved by both the board and the board of medicine.

[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.4(148,154B) Prescribing—joint rule. This rule applies to both conditional prescribing psychologists and prescribing psychologists. A psychologist shall comply with all prescription requirements described in 657—subrule 8.19(1). The following limits apply to a psychologist's prescriptive authority:

1. A psychologist shall only prescribe psychotropic medications for the treatment of mental disorders.

2. A psychologist shall only prescribe psychotropic medications in situations where the psychologist has adequate education and training to safely prescribe.

3. A prescription shall identify the prescriber as a "psychologist certified to prescribe" and shall include the Iowa license number of the psychologist.

4. A prescription issued by a conditional prescribing psychologist shall contain the name of the supervising physician overseeing the care of the patient.

5. A psychologist shall not delegate prescriptive authority to any other person.

6. A psychologist is prohibited from prescribing narcotics as defined in Iowa Code section 124.101.

7. A psychologist shall maintain an active DEA registration and an active CSA registration in order to dispense, prescribe, or administer controlled substances.

8. A psychologist shall not self-prescribe nor prescribe to any person who is a member of the psychologist's immediate family or household.

9. Before prescribing a psychotropic medication that is classified as a controlled substance, a psychologist shall check the patient's prescriptive profile using the Iowa prescription monitoring program.

10. To prescribe to a patient who is pregnant or lactating, a psychologist shall consult with the patient's obstetrician-gynecologist or the physician managing the patient's pregnancy or postpartum care regarding all prescribing decisions. A psychologist shall not prescribe a psychotropic medication to a patient if the patient's obstetrician-gynecologist or the physician managing care objects on the basis of a contraindication.

11. To prescribe to a patient who has a serious medical condition, including but not limited to heart disease, kidney disease, liver disease, cancer, stroke, seizures, or comorbid psychological conditions, or to a patient who has a developmental or intellectual disability, a psychologist shall consult with the physician who is managing the comorbid condition for that patient regarding all prescribing decisions. A psychologist shall not prescribe a psychotropic medication if the patient's physician objects on the basis of a contraindication.

12. A psychologist shall not prescribe a new psychotropic medication, discontinue a psychotropic medication, or change the dosage of a psychotropic medication if the supervising physician or collaborating physician objects on the basis of a contraindication.

[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.5(148,154B) Consultation with primary care physicians—joint rule. This rule applies to both conditional prescribing psychologists and prescribing psychologists. A psychologist shall maintain a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical conditions, and significant changes in the patient's medical or psychological condition are discussed.

19.5(1) Requirement for a primary care physician. A patient must have a designated primary care physician in order for a psychologist to have the ability to prescribe psychotropic medications to the patient. If a patient does not have a designated primary care physician, a psychologist shall refer the patient to a primary care physician prior to prescribing psychotropic medications to the patient. A

psychologist shall not prescribe psychotropic medications to a patient until the patient has established care with a primary care physician.

19.5(2) Requirement for a release. A psychologist shall obtain a release of information from the patient, or the patient's legal guardian when appropriate, authorizing the sharing of the patient's health information between the psychologist and the patient's primary care physician. A psychologist shall not prescribe psychotropic medications to a patient who refuses to sign a release.

19.5(3) Cooperation and consultation with primary care physicians. A psychologist shall contact each patient's primary care physician on at least a quarterly basis and shall contact the primary care physician to relay information regarding the care of a patient whenever the following occur:

a. A psychologist is considering adding a new psychotropic medication to a patient's medication regimen. A psychologist shall not prescribe a new psychotropic medication if the patient's primary care physician objects on the basis of a contraindication.

b. A psychologist is discontinuing or changing the dosage of a psychotropic medication.

c. A patient experiences adverse effects from any medication prescribed by the psychologist that may be related to the patient's medical condition.

d. A psychologist receives the results of laboratory tests related to the medical care of a patient.

e. A psychologist notes a change in a patient's mental condition that may affect the patient's medical treatment.

[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.6(148,154B) Collaborative practice—joint rule.

19.6(1) A prescribing psychologist shall have one or more collaborating physicians at all times, as evidenced by a current collaborative practice agreement. Prior to executing a collaborative practice agreement, a prescribing psychologist and a collaborating physician shall review and discuss each other's relevant education, training, experience, and competencies to determine whether a collaborative practice is appropriate and to facilitate drafting a suitable collaborative practice agreement. A collaborative relationship between a prescribing psychologist and a collaborating physician shall ensure patient safety and optimal clinical outcomes. Collaboration may be done in person or via electronic communication in accordance with these rules. A physician shall not serve as a collaborating physician for more than two prescribing psychologists at one time. A prescribing psychologist shall not prescribe without a current written collaborative practice agreement with a collaborating physician in place. All collaborative relationships shall be reviewed and evaluated on an annual basis to ensure that the prescribing psychologist is competent to safely prescribe psychotropic medications to patients and that the collaborating physician is providing appropriate feedback to the prescribing psychologist. A collaborative practice agreement shall establish the parameters of the collaborative practice that are mutually agreed upon by the prescribing psychologist and the collaborating physician and shall be reviewed on an annual basis.

19.6(2) A collaborative practice agreement shall include the following:

a. *Prescribing psychologist information.* The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the prescribing psychologist.

b. *Collaborating physician information.* The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the collaborating physician.

c. *Time period.* The time period covered by the agreement.

d. *Locations and settings.* The locations and settings where collaborative practice will occur.

e. *Collaboration.* A provision indicating that the collaborating physician and prescribing psychologist shall ensure that the collaborating physician is available for timely collaboration with a prescribing psychologist, either in person or via electronic communication, in accordance with these rules.

f. *Scope of practice.* The scope of practice agreed upon by the collaborating physician and the prescribing psychologist, as it relates to the prescribing psychologist's prescribing of psychotropic

medications, including provisions to ensure that the prescribing psychologist's practice complies with all provisions of these rules.

g. Clinical protocols, practice guidelines, and care plans. Clinical protocols, practice guidelines, and care plans relevant to the scope of practice authorized.

h. Methods of communication. A description of how a prescribing psychologist and a collaborating physician may contact each other for consultation.

i. Limitations on psychotropic medications. A description of any limitations on the range of psychotropic medications the prescribing psychologist may prescribe. The collaborative practice agreement shall also include a provision indicating that the collaborating physician and prescribing psychologist shall ensure that the prescribing psychologist only prescribes psychotropic medications that are consistent with the prescribing psychologist's education, training, experience, and competence.

j. Limitations on patient populations. A description of any limitations on the types of populations that the prescribing psychologist may treat with psychotropic medications. The collaborative practice agreement shall also include a provision indicating that the collaborating physician and prescribing psychologist shall ensure that the prescribing psychologist only provides psychopharmacology services to patient populations that are within the prescribing psychologist's education, training, experience, and competence.

k. Release of information. A provision requiring the prescribing psychologist to obtain a release of information from all patients who are considered for psychopharmacological intervention, authorizing the prescribing psychologist to share the patient's health information with the collaborating physician.

l. Chart review. A provision indicating that the collaborating physician and prescribing psychologist shall ensure that the collaborative physician personally reviews and documents review of at least 10 percent of the prescribing psychologist's patient charts on a quarterly basis in each of the following categories:

- (1) Juvenile patients,
- (2) Pregnant or lactating patients,
- (3) Elderly patients,
- (4) Patients with serious medical conditions, and
- (5) All other patients.

m. Annual review. A provision requiring an annual review and evaluation of the collaborative relationship and the collaborative practice agreement.

n. Consultation between the prescribing psychologist and the collaborating physician. A provision requiring that the prescribing psychologist consult with the collaborating physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications. A prescribing psychologist shall not prescribe a new psychotropic medication, discontinue a psychotropic medication, or change the dosage of a psychotropic medication if the collaborating physician objects on the basis of a contraindication.

o. Consultation between the collaborating physician and the primary care physician. A provision requiring that the collaborating physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

p. Termination. A provision describing how the agreement can be terminated and the process for notifying affected patients if there will be an interruption in services.

q. Signatures. Signatures of the prescribing psychologist and all collaborating physicians.
[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.7(148,154B) Complaints—joint rule. Any complaint received by the board alleging a violation of this chapter shall be forwarded to the board of medicine. Any complaint received by the board of medicine alleging a violation of this chapter shall be forwarded to the board.

[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.8(148,154B) Joint waiver—joint rule. Any rule identified as a joint rule may only be waived upon approval by both the board and the board of medicine.

[ARC 4249C, IAB 1/16/19, effective 2/20/19; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—19.9(148,154B) Amendment—joint rule. Any rule identified as a joint rule may only be amended by agreement of the board and board of medicine through a joint rule-making process.
[ARC 4249C, IAB 1/16/19, effective 2/20/19]

653—19.10(17A,124,147,148,154B,272C) Standards of practice—supervision of a conditional prescribing psychologist. A supervising physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice and who supervises a conditional prescribing psychologist. A supervising physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A supervising physician shall fully comply with the following standards of practice.

19.10(1) Supervision. A supervising physician shall provide appropriate oversight and direction to a conditional prescribing psychologist during the period of supervised practice to achieve patient safety and optimal clinical outcomes. A supervising physician shall ensure that appropriate clinical examinations and necessary testing are performed and that all psychopharmacology services provided are appropriate for the patient's condition. Supervision may be in person or via electronic communications in accordance with these rules.

19.10(2) Primary supervising physician. A supervising physician shall determine whether the supervising physician has been designated as a conditional prescribing psychologist's primary supervising physician and shall fulfill the responsibilities of the primary supervising physician in accordance with these rules. A conditional prescribing psychologist may have more than one supervising physician.

19.10(3) Maximum number of conditional prescribing psychologists. A supervising physician shall not supervise more than two conditional prescribing psychologists at one time.

19.10(4) Minimum period of supervision. The primary supervising physician shall ensure that a conditional prescribing psychologist completes a minimum of two years of supervised practice prescribing psychotropic medications to patients with mental disorders in accordance with these rules in order for the conditional prescribing psychologist to be eligible to apply for a prescription certificate.

19.10(5) Minimum number of patients. The primary supervising physician shall ensure that a conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder for whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient. The primary supervising physician shall ensure that a conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

19.10(6) Initial assessment. Prior to supervising a conditional prescribing psychologist, each supervising physician shall assess the conditional prescribing psychologist's relevant education, training, experience, and competence.

19.10(7) Scope of practice. Each supervising physician shall ensure that all psychopharmacology services provided by a conditional prescribing psychologist are within the competence and scope of practice of the supervising physician and the conditional prescribing psychologist.

19.10(8) Prescriptive authority. Each supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.10(9) Prescriptions. A supervising physician shall ensure that each prescription issued by a conditional prescribing psychologist identifies the prescriber as a "psychologist certified to prescribe" and includes the Iowa license number of the conditional prescribing psychologist and the name of the supervising physician.

19.10(10) Active DEA and CSA registration. A supervising physician shall ensure that a conditional prescribing psychologist has an active DEA registration and CSA registration at all times during the period of supervision.

19.10(11) Patient populations. A supervising physician shall ensure that a conditional prescribing psychologist only provides psychopharmacology services to patient populations within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician

may establish limitations on the types of populations to whom a conditional prescribing psychologist may provide psychopharmacology services based on the conditional prescribing psychologist's education, training, experience, and competence.

19.10(12) *Psychotropic medications.* A supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications that are within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician may establish limitations on the types of psychotropic medications that a conditional prescribing psychologist may prescribe based on the conditional prescribing psychologist's education, training, experience, and competence.

19.10(13) *Specialization.* A supervising physician shall ensure that a conditional prescribing psychologist has completed the following training during the supervised practice period to be eligible to prescribe psychotropic medications to the respective population as a prescribing psychologist:

a. Children. To prescribe to patients who are less than 17 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A pediatric practice,
- (2) A child and adolescent practice, or
- (3) A general practice provided the conditional prescribing psychologist treats a minimum of 50 patients who are less than 17 years of age.

b. Elderly patients. To prescribe to patients who are over 65 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A geriatric practice, or
- (2) A general practice with patients across the lifespan including patients who are over 65 years of age.

c. Serious medical conditions. To prescribe to patients with serious medical conditions including, but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, a supervising physician shall ensure that a conditional prescribing psychologist has completed at least one year prescribing psychotropic medications to patients with serious medical conditions if the conditional prescribing psychologist intends to treat patients with serious medical conditions after the supervised practice period.

19.10(14) *Informed consent.* A supervising physician shall ensure that a conditional prescribing psychologist obtains appropriate informed consent before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.10(15) *Release of information.* A supervising physician shall ensure that a conditional prescribing psychologist obtains a release of information authorizing the conditional prescribing psychologist to share information with the supervising physician before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.10(16) *Primary care physician.* A supervising physician shall ensure that each patient has a designated primary care physician before a conditional prescribing psychologist provides psychopharmacology services to a patient. A supervising physician shall ensure that a conditional prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A supervising physician shall ensure that a conditional prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the conditional prescribing psychologist is providing psychopharmacology services to a patient.

19.10(17) *Chart reviews.* A supervising physician shall personally review a representative sample of the conditional prescribing psychologist's patient charts.

19.10(18) *Performance evaluations.* A supervising physician shall regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

19.10(19) Supervision plan. Prior to supervising a conditional prescribing psychologist, a supervising physician shall ensure that a conditional prescribing psychologist has an approved written supervision plan in place. A template may be obtained from the boards of medicine and psychology. The supervision plan shall define the nature and extent of the supervisory relationship and outline specific parameters for review of the supervisory relationship. The supervision plan shall take into account the supervising physician's and conditional prescribing psychologist's relevant education, training, experience, and competence and the nature and scope of the psychopharmacology services to be provided. The supervising physician and conditional prescribing psychologist shall each maintain a copy of the supervision plan and provide a copy of the plan to the boards of medicine and psychology upon request. The supervision plan shall include the following:

a. Conditional prescribing psychologist's information. The name, license number, address, telephone number, and email address of the conditional prescribing psychologist.

b. Supervising physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the supervising physician.

c. Designation of the primary supervising physician. Designation of the conditional prescribing psychologist's primary supervising physician.

d. Period of supervision. The beginning date of the supervision plan and estimated date of completion.

e. Locations and settings. A description of the locations and settings where and with whom supervision will occur.

f. Scope of practice. A description of the scope of practice of the supervising physician and the conditional prescribing psychologist.

g. Methods of communication. A description of how the supervising physician and conditional psychologist may communicate for appropriate supervision.

h. Initial assessment. A description of the steps the supervising physician has taken to assess a conditional prescribing psychologist's relevant education, training, experience, and competence prior to supervising the conditional prescribing psychologist.

i. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the conditional prescribing psychologist may prescribe consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Limitations on patient populations. A description of any limitations on the types of populations the conditional prescribing psychologist may treat with psychotropic medications consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

k. Expectations and responsibilities. A description of the expectations and responsibilities of the supervisory relationship.

l. Specialization. A description of the specialized training to be completed by the conditional prescribing psychologist in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with subrule 19.3(4).

m. Chart reviews. A description of the steps the supervising physician has taken to personally review a representative sample of the conditional prescribing psychologist's patient charts.

n. Consultation between the supervising physician and the primary care physician. A requirement that the supervising physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

o. Performance evaluations. A description of the steps the supervising physician has taken to regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

p. Termination of the supervision plan. A description of how the supervision plan may be terminated and the process for notifying affected patients.

q. Signatures. Signatures of the conditional prescribing psychologist and all supervising physicians.

r. Amendment to the supervision plan. A requirement that a conditional prescribing psychologist shall inform the board of psychology of any amendments to the supervision plan, including the addition of any supervising physicians, within 30 days of the change and that any amendment to a supervisory plan be subject to approval of the board of psychology.

s. Request for extension. If the primary supervising physician determines that a conditional prescribing psychologist is unable to successfully complete the supervised practice prior to the expiration of the conditional prescription certificate, the conditional prescribing psychologist may request an extension of the conditional prescription certificate provided that the conditional prescribing psychologist and the primary supervising physician can demonstrate that the conditional prescribing psychologist is likely to successfully complete the supervised practice within the extended time requested.

19.10(20) Certification of completion. At the conclusion of the supervised practice period, the primary supervising physician shall certify the following:

a. Supervision. That each supervising physician has provided supervision to the conditional prescribing psychologist in accordance with these rules.

b. Minimum period of supervised practice. That the conditional prescribing psychologist has successfully completed a minimum of two years of supervised practice.

c. Minimum number of patients. That the conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder with whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient, and that the conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

d. Specialization. That a conditional prescribing psychologist who intends to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, has successfully completed a minimum of one year of supervised practice with the respective populations during the supervised practice period.

e. Demonstrated competence. That a conditional prescribing psychologist has successfully completed the supervised practice period and demonstrated competence in psychopharmacology by demonstrating competency in the milestones sufficient to obtain a prescription certificate in accordance with paragraph 19.2(3) "f."

[ARC 4835C, IAB 12/18/19, effective 1/22/20]

653—19.11(17A,124,147,148,154B,272C) Standards of practice—collaboration with a prescribing psychologist. A collaborating physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice, and who serves as a resource for a prescribing psychologist pursuant to a collaborative practice agreement. A collaborating physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A collaborating physician shall fully comply with the following standards of practice:

19.11(1) Collaboration. A collaborating physician shall provide appropriate collaboration with a prescribing psychologist to achieve patient safety and optimal clinical outcomes. A collaborating physician shall ensure that appropriate clinical examinations and necessary testing are performed and that all psychopharmacology services provided are appropriate for the patient's condition. Collaboration may be in person or via electronic communications in accordance with these rules. A prescribing psychologist may have more than one collaborating physician.

19.11(2) *Maximum number of prescribing psychologists.* A physician shall not serve as a collaborating physician for more than two prescribing psychologists at one time.

19.11(3) *Initial assessment.* Prior to serving as a collaborating physician, a physician shall assess a prescribing psychologist's relevant education, training, experience, and competence.

19.11(4) *Scope of practice.* A collaborating physician shall ensure that all psychopharmacology services provided by a prescribing psychologist are within the competence and scope of practice of the collaborating physician and the prescribing psychologist.

19.11(5) *Prescriptive authority.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.11(6) *Delegation.* A collaborating physician shall ensure that a prescribing psychologist does not delegate prescriptive authority to any other person.

19.11(7) *Narcotics.* A collaborating physician shall ensure that a prescribing psychologist does not prescribe narcotics.

19.11(8) *Active DEA and CSA registration.* A collaborating physician shall ensure that a prescribing psychologist has an active DEA registration and CSA registration at all times during the period of collaboration.

19.11(9) *Patient populations.* A collaborating physician shall ensure that a prescribing psychologist only provides psychopharmacology services to patient populations within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of populations to whom a prescribing psychologist may provide psychopharmacology services based on the prescribing psychologist's education, training, experience, and competence.

19.11(10) *Psychotropic medications.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications that are within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of psychotropic medications that a prescribing psychologist may prescribe based on the prescribing psychologist's education, training, experience, and competence.

19.11(11) *Specialization.* A collaborating physician shall ensure that a prescribing psychologist has completed at least one year of the required two years of supervised practice with the respective population in accordance with subrule 19.3(4) before the prescribing psychologist provides psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities.

19.11(12) *Informed consent.* A collaborating physician shall ensure that a prescribing psychologist obtains appropriate informed consent before a prescribing psychologist provides psychopharmacology services to a patient.

19.11(13) *Release of information.* A collaborating physician shall ensure that a prescribing psychologist obtains a release of information authorizing the prescribing psychologist to share information with the collaborating physician before the prescribing psychologist provides psychopharmacology services to a patient.

19.11(14) *Primary care physician.* A collaborating physician shall ensure that each patient has a designated primary care physician before a prescribing psychologist provides psychopharmacology services to a patient. A collaborating physician shall ensure that a prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A collaborating physician shall ensure that a prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the prescribing psychologist is providing psychopharmacology services to a patient.

19.11(15) *Chart reviews.* A collaborating physician shall personally review a representative sample of the prescribing psychologist's patient charts.

19.11(16) *Performance evaluations.* A collaborating physician shall regularly evaluate the clinical judgment, skills and performance of a prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

19.11(17) *Collaborative practice agreement.* Prior to serving as a collaborating physician for a prescribing psychologist, the collaborating physician shall ensure that the prescribing psychologist has a written collaborative practice agreement in place. A template may be obtained from the boards of medicine and psychology. The collaborative practice agreement shall define the nature and extent of the collaborative relationship and outline specific parameters for review of the collaborative relationship. The collaborative practice agreement shall take into account the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence and the nature and scope of the psychopharmacology services to be provided. The collaborating physician shall review the terms of the collaborative practice agreement with the prescribing psychologist at least once each year. The collaborating physician and prescribing psychologist shall each maintain a copy of the collaborative practice agreement and provide a copy of the agreement to the boards of medicine and psychology upon request. The collaborative practice agreement shall include the following:

a. Prescribing psychologist's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the prescribing psychologist.

b. Collaborating physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the collaborating physician.

c. Period of collaboration. The time period covered by the collaborative practice agreement.

d. Locations and settings. A description of the locations and settings where and with whom collaborative practice will occur.

e. Scope of practice. A description of the scope of practice of the collaborating physician and the prescribing psychologist.

f. Methods of communication. A description of how the collaborating physician and prescribing psychologist may communicate for appropriate collaboration.

g. Initial assessment. A description of the steps the collaborating physician has taken to assess a prescribing psychologist's relevant education, training, experience, and competence prior to collaborating with a prescribing psychologist.

h. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the prescribing psychologist may prescribe consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

i. Limitations on patient populations. A description of any limitations on the types of populations the prescribing psychologist may treat with psychotropic medications consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Expectations and responsibilities. A description of the expectations and responsibilities of the collaborative relationship.

k. Specialization. A description of the specialized training the prescribing psychologist has completed in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with subrule 19.3(4).

l. Chart reviews. A description of the steps the collaborating physician has taken to personally review a representative sample of the prescribing psychologist's patient charts.

m. Consultation between the collaborating physician and the primary care provider. A requirement that the collaborating physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

n. Performance evaluations. A description of the steps the collaborating physician has taken to regularly evaluate the clinical judgment, skills and performance of the prescribing psychologist to safely

provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

o. Termination of the collaborative practice agreement. A provision describing how the collaborative practice agreement may be terminated and the process for notifying affected patients.

p. Signatures. Signatures of the collaborating physician and the prescribing psychologist.
[ARC 4835C, IAB 12/18/19, effective 1/22/20]

653—19.12(17A,124,147,148,272C) Grounds for discipline. A physician who fails to comply with these rules may be subject to disciplinary action by the board of medicine.

[ARC 4835C, IAB 12/18/19, effective 1/22/20]

These rules are intended to implement Iowa Code chapters 148 and 154B.

[Filed ARC 4249C (Notice ARC 3905C, IAB 8/1/18), IAB 1/16/19, effective 2/20/19]

[Filed ARC 4835C (Notice ARC 4663C, IAB 9/25/19), IAB 12/18/19, effective 1/22/20]

[Filed ARC 5600C (Notice ARC 5370C, IAB 12/30/20), IAB 5/5/21, effective 6/9/21]

CHAPTER 20
LICENSURE OF GENETIC COUNSELORS

653—20.1(148H) Purpose. The licensure of genetic counselors is established to ensure that practitioners are qualified to provide to Iowans genetic counseling with reasonable skill and safety. The provisions of Iowa Code chapters 147, 148H, and 272C authorize the board of medicine to establish eligibility requirements for licensure, evaluate the credentials of applicants for licensure, issue licenses to qualified applicants, institute continuing education requirements, investigate complaints and reports alleging that licensed genetic counselors have violated statutes and rules governing the practice of genetic counseling, make available participation in the Iowa physician health program, and discipline licensed genetic counselors found guilty of infractions as provided in state law and board rules. [ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.2(148H) Scope of chapter. This chapter shall not be construed to apply to any of the following:

1. A physician or surgeon or an osteopathic physician or surgeon licensed under Iowa Code chapter 148, a registered nurse or an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a physician assistant licensed under Iowa Code chapter 148C, or other persons licensed under Iowa Code chapter 147 when acting within the scope of the person's profession and doing work of a nature consistent with the person's education and training.
2. A person who is certified by the American Board of Medical Genetics and Genomics as a doctor of philosophy and is not a genetic counselor licensed pursuant to Iowa Code chapter 148H.
3. A person employed as a genetic counselor by the federal government or an agency thereof if the person provides genetic counseling services solely under the direction and control of the entity by which the person is employed.
4. A genetic counseling intern.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.3(148H) Definitions.

"Active candidate status" means a person has met the requirements established by the American Board of Genetic Counseling to take the American Board of Genetic Counseling certification examination in general genetics and genetic counseling and has been granted this designation by the American Board of Genetic Counseling.

"American Board of Genetic Counseling" or *"ABGC"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

"American Board of Medical Genetics and Genomics" or *"ABMGG"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

"Board" means the board of medicine.

"Committee" means the licensure committee of the board.

"Genetic counseling" means the provision of services by a person who qualifies for a license under Iowa Code chapter 148H.

"Genetic counseling intern" means a student enrolled in a genetic counseling program accredited by the accreditation council for genetic counseling or the American Board of Medical Genetics and Genomics.

"Genetic counselor" means a person who is licensed under Iowa Code chapter 148H to engage in the practice of genetic counseling.

"Qualified supervisor" means any person who is a genetic counselor licensed under Iowa Code chapter 148H, a physician licensed under Iowa Code chapter 148, or an advanced registered nurse practitioner licensed under Iowa Code chapter 152.

"Supervision" means supervision by a qualified supervisor who has the overall responsibility of assessing the work of a provisional licensee, provided that an annual supervision contract signed by the

qualified supervisor and the provisional licensee is on file with both parties. “Supervision” does not require the qualified supervisor’s presence during the performance of services.
[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.4(148H) Scope of practice. A person licensed pursuant to Iowa Code chapter 148H may do any of the following:

1. Obtain and evaluate individual, family, and medical histories to determine genetic risk for genetic and medical conditions and diseases in a patient, the patient’s offspring, and other family members.
2. Discuss the features, history, means of diagnosis, genetic and environmental factors, and management of risk for genetic and medical conditions and diseases.
3. Identify, order, and coordinate genetic laboratory tests and other diagnostic studies as appropriate for the genetic assessment of a patient.
4. Refer a patient to a specialty or subspecialty department as necessary for the purpose of collaborating on diagnosis and treatment involving multiple body systems and general medical management.
5. Integrate genetic laboratory test results and other diagnostic studies with personal and family medical history to assess and communicate risk factors for genetic and medical conditions and diseases.
6. Explain the clinical implications of genetic laboratory tests and other diagnostic studies and their results.
7. Evaluate the responses of a patient or patient’s family to the condition or risk of recurrence and provide patient-centered genetic counseling and anticipatory guidance.
8. Identify and utilize community resources that provide medical, educational, financial, and psychosocial support and advocacy.
9. Provide written documentation of medical, genetic, and counseling information for families and health care professionals.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.5(148H) Titles used. A genetic counselor licensed under Iowa Code chapter 148H may use the words “genetic counselor” or “licensed genetic counselor” or the corresponding abbreviation “LGC” after the person’s name. Persons who possess a provisional license shall add the designation “provisional licensed genetic counselor.”

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.6(148H) Qualifications for licensure.

20.6(1) Each applicant for licensure under Iowa Code chapter 148H shall:

- a. Submit an application form and supporting documentation as prescribed by the board.
- b. Hold active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

20.6(2) A licensee shall maintain active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.7(148H) Qualifications for provisional licensure. The board may issue a provisional license to an applicant who meets all of the requirements for licensure except for the certification component and who has been granted active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

20.7(1) The applicant shall submit a provisional license application form, proof of active candidate status, and supporting documentation prescribed by the board.

20.7(2) A provisional license shall expire and become inactive upon the earliest of the following:

- a. Issuance of a license as a genetic counselor by the board.
- b. Loss of active candidate status.

(1) A person holding a provisional license which is inactive due to loss of active candidate status may submit an application for reactivation of the provisional license upon demonstrating that active candidate status has been reestablished.

(2) An application for extension of a provisional license shall be signed by a qualified supervisor.

- c. The date printed on the provisional license.

20.7(3) A person with a provisional license shall work at all times under the supervision of a qualified supervisor.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.8(147,148H) Application requirements.

20.8(1) *Application for licensure.* To apply for a license to practice genetic counseling, an applicant shall:

- a. Submit the completed application form provided by the board, including required credentials and documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

- b. Pay the nonrefundable initial application fee identified in 653—paragraph 8.14(2) “a” and pay the fee identified in 653—paragraph 8.14(2) “f” for the evaluation of the fingerprint packet and the national criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

20.8(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

- a. The applicant’s full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

- b. A photograph of the applicant suitable for positive identification;

- c. A chronology accounting for all time periods from the date the applicant entered a genetic counseling training program or educational institution to the date of the application;

- d. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice genetic counseling, including license, certificate of registration or certification number and date of issuance;

- e. Full disclosure of the applicant’s involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process;

- f. A statement disclosing and explaining any informal or nonpublic actions, such as letters of warning, letters of education, any confidential retraining, or any kind of confidential action taken toward a genetic counselor’s certification or license which is not public discipline; warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

- g. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

- h. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure;

- i. A statement of the applicant’s physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in the practice of genetic counseling and provide patients with safe and healthful care; and

j. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

20.8(3) Application cycle. If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—paragraph 8.14(2)“*b*” and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, an applicant must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

20.8(4) Applicant responsibilities. An applicant for licensure to practice genetic counseling bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national certifying organizations, health facilities, and educational institutions providing the information specified in subrule 20.8(2);

b. Providing accurate, up-to-date, and truthful information on the application form including, but not limited to, that specified under subrule 20.8(2) related to prior professional experience, education, training, active certification, licensure, and disciplinary history.

20.8(5) Licensure application review process. A process established by the board shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff shall notify the applicant about how to resolve any problems identified by the reviewer. An applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates that the application is complete and that the application does not raise any questions or concerns regarding the applicant's qualifications for licensure, staff may administratively issue the license. Staff may issue the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively issue the license.

(2) If there are questions or concerns, an Iowa-licensed genetic counselor may be consulted.

(3) If any concern exists, staff shall refer the application to the committee.

e. Staff shall refer to the committee for review matters which include, but are not limited to, falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, and after consultation with an Iowa-licensed genetic counselor, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

1. Successfully complete board-approved continuing education or remediation;
2. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board;
3. If the genetic counselor is employed or has an offer of employment, successfully complete any other pathway as agreed upon by the board and the genetic counselor's employer;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

1. Successfully complete board-approved continuing education or remediation;

2. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board;

3. If the genetic counselor is employed or has an offer of employment, successfully complete any other pathway as agreed upon by the board and the genetic counselor's employer;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

20.8(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, and after consultation with an Iowa-licensed genetic counselor, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in this chapter pursuant to Iowa Code section 148H.3.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148H.7 or in rule 653—20.20(147,148H,272C).

20.8(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

20.8(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

20.8(9) Hearing. If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with rule 653—25.30(17A).

- a. License denial hearings are contested cases open to the public.
- b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.
- c. Evidence supporting the denial of the license may be presented by an assistant attorney general.
- d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.
- e. The board, after a hearing on license denial, may issue or deny the license. The board shall state the reasons for its decision and may issue the license, issue the license with restrictions, or deny the license. The final decision is a public record.
- f. Judicial review of a final order of the board denying licensure, or issuing a license with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

20.8(10) Finality. If an applicant does not appeal a preliminary notice of denial in accordance with subrule 20.8(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

20.8(11) Failure to pursue appeal. If an applicant appeals a preliminary notice of denial in accordance with subrule 20.8(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

20.8(12) Waiver prohibited. Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—20.9(147,148H) Display of license and notification required to change the board's data system.

20.9(1) Display of license. Licensed genetic counselors shall display the license issued by the board in a conspicuous place in their primary place of business.

20.9(2) Change of contact information. Licensees shall notify the board within one month of a change in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board.

20.9(3) Change of full legal name. A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

20.9(4) Deceased. A licensee's file shall be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.10(147,148H,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148H.3, a license expires on October 31 of odd-numbered years and can be renewed for the fee identified in 653—paragraph 8.14(2) "c."

20.10(1) The applicant for renewal shall provide:

- a. A renewal application provided by the board.
- b. A letter sent directly from the ABGC or ABMGG to the board verifying that the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a

letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

c. Satisfactory evidence to the board that in the period since the license was issued or last renewed, the applicant has completed 30 hours of National Society of Genetic Counselors or ABMGG continuing education units as approved by the board.

20.10(2) Expiration date. Certificates of licensure to practice genetic counseling shall expire on October 31 in odd years.

20.10(3) Prorated fees. The first renewal fee for a license shall be prorated on a monthly basis according to the date of issue.

20.10(4) Renewal requirements and penalties for late renewal. Each licensee shall be sent a renewal notice at least 60 days prior to the expiration date. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

a. When online renewal is used, the licensee must complete the online renewal prior to midnight on December 31 in order to ensure that the license will not become inactive. The license becomes inactive and invalid at 12:01 a.m. on January 1.

b. Upon receipt of the completed renewal application, staff shall administratively issue a license that expires on October 31 of odd-numbered years. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration.

c. Every renewal shall be displayed in connection with the original certificate of licensure.

d. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty fee identified in 653—paragraph 8.14(2) “*d*” shall be assessed for renewal in the grace period, a period up until January 1 when the license becomes inactive if not renewed.

20.10(5) Inactive license. Failure of a licensee to renew by January 1 will result in invalidation of the license, and the license will become inactive.

a. Licensees are prohibited from engaging in the practice of genetic counseling once the license is inactive.

b. Having a genetic counselor license in inactive status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148H.7.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19]

653—20.11(147,272C) Reinstatement of an inactive license.

20.11(1) Reinstatement requirements. Licensees who allow their licenses to go inactive by failing to renew may apply for reinstatement of a license. Pursuant to Iowa Code section 147.11, applicants for reinstatement shall:

a. Submit upon forms provided by the board a completed application for reinstatement of a license to practice genetic counseling. The application shall include the following information:

(1) The applicant’s full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant’s involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority; an educational institution; a training or research program; or a health facility in any jurisdiction.

(5) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care.

(6) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(7) A chronology accounting for all time periods from the date of initial licensure.

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—paragraph 8.14(2) “*f*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reinstatement fee identified in 653—paragraph 8.14(2) “*g*” plus the fee identified in 653—paragraph 8.14(2) “*f*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from the ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

e. Meet any new requirements instituted since the license lapsed.

20.11(2) Reinstatement for an applicant who has been out of practice for three years. If an applicant for reinstatement has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

a. Successfully complete board-approved continuing education or remediation.

b. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board.

c. Successfully complete any other pathway as agreed upon by the board.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19]

653—20.12(272C) Code of ethics. The NSGC Code of Ethics prepared and approved by the National Society of Genetic Counselors shall be utilized by the board as guiding principles in the practice of genetic counseling in this state.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.13(272C) Nonpayment of state debt. 653—Chapter 12 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.14(272C) Standards of practice—office practices. Rule 653—13.7(147,148,272C) shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.15(272C) Iowa physician health committee. 653—Chapter 14 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.16(272C) Child support noncompliance. 653—Chapter 15 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.17(272C) Student loan default or delinquency—prohibited grounds for discipline. The board shall not suspend or revoke a license issued by the board to a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or

public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

[ARC 4979C, IAB 3/11/20, effective 4/15/20]

653—20.18(272C) Military service and veteran reciprocity. 653—Chapter 18 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.19(272C) Mandatory reporting. 653—Chapter 22 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.20(147,148H,272C) Grounds for discipline of genetic counselors. The board has authority to impose discipline for any violation of Iowa Code chapter 147, 148H, or 272C or the rules promulgated thereunder. These grounds for discipline apply to genetic counselors. This rule is not subject to waiver pursuant to 653—Chapter 3 or any other provision of law. The board may impose any of the disciplinary sanctions set forth in 653—subrule 25.25(1) when the board determines that the licensee is guilty of any of the following acts or offenses:

20.20(1) Violating any of the grounds for revocation or suspension of a license as listed in Iowa Code section 147.55, 148H.7, or 272C.10.

20.20(2) Professional incompetency. Professional incompetency includes, but is not limited to, any of the following:

- a. Willful or repeated gross malpractice;
- b. Willful or gross negligence;
- c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the genetic counselor's practice;
- d. A substantial deviation by the genetic counselor from the standards of learning or skill ordinarily possessed and applied by other genetic counselors in the state of Iowa acting in the same or similar circumstances;
- e. A failure by a genetic counselor to exercise in a substantial respect that degree of care which is ordinarily exercised by an average genetic counselor in the state of Iowa acting in the same or similar circumstances;

f. A willful or repeated departure from or failure to conform to the minimal standard of acceptable and prevailing practice of genetic counseling in the state of Iowa.

20.20(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes, but is not limited to, the failure of the genetic counselor to possess and exercise that degree of skill, learning, and care expected of a reasonable, prudent genetic counselor acting in the same or similar circumstances in this state, or when a genetic counselor is unable to practice genetic counseling with reasonable skill and safety as a result of mental or physical impairment, or chemical abuse.

20.20(4) Unprofessional conduct. Engaging in unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice, or good morals, whether the act is committed in the scope of the licensee's practice or otherwise, and whether the act is committed in this state or elsewhere; or a violation of the principles of ethics applicable to genetic counselors.

20.20(5) Sexual misconduct. Engaging in sexual misconduct includes, but is not limited to, a genetic counselor engaging in conduct set forth in 653—subrule 13.7(4) (sexual conduct) or 13.7(6) (sexual harassment) as interpreted by the board.

20.20(6) Substance abuse. Substance abuse includes, but is not limited to, excessive use of alcohol, drugs, narcotics, chemicals, or other substances in a manner which may impair a licensee's ability to practice the profession with reasonable skill and safety.

20.20(7) Physical or mental impairment. Physical or mental impairment includes, but is not limited to, any physical, neurological, or mental condition which may impair a genetic counselor's ability to practice the profession with reasonable skill and safety. Being adjudicated mentally incompetent by a court of competent jurisdiction shall automatically suspend a license for the duration of the license unless the board orders otherwise.

20.20(8) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory, or jurisdiction, as defined in Iowa Code section 148.6(2) “b.”

20.20(9) Violation of the laws or rules governing the practice of genetic counseling in this state, another state, the United States, or any country, territory, or jurisdiction. Violation of the laws or rules governing the practice of genetic counseling includes, but is not limited to, willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148H, or 272C or any other state or federal laws governing the practice of genetic counseling.

20.20(10) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

20.20(11) Violation of an initial agreement or health contract entered into with the Iowa physician health program (IPHP).

20.20(12) Failure to comply with an evaluation order under Iowa Code section 272C.9(1).

20.20(13) Knowingly making misleading, deceptive, untrue, or fraudulent representations in the practice of genetic counseling. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of genetic counseling includes, but is not limited to, an intentional perversion of the truth, either orally or in writing, by a genetic counselor in the practice of genetic counseling.

20.20(14) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice genetic counseling in this state, and includes false representations of material fact, either by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for license in this state.

20.20(15) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a licensee’s having made misleading, deceptive, or untrue representations as to the genetic counselor’s competency to perform professional services for which the licensee is not qualified to perform by education, training, or experience.

20.20(16) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making known to the public information which is false, deceptive, misleading, or promoted through fraud or misrepresentation and includes statements which may consist of, but are not limited to:

- a. Inflated or unjustified claims which lead to expectations of favorable results;
- b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty for which the licensee is not qualified;
- c. Representations that are likely to cause an average person to misunderstand; or
- d. Extravagant claims or claims of extraordinary skill not recognized by the profession of genetic counseling.

20.20(17) Obtaining any fee by fraud or misrepresentation.

20.20(18) Acceptance of remuneration for referral of a patient to other health professions in violation of the law or National Society of Genetic Counselors Code of Ethics.

20.20(19) Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.

20.20(20) Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of genetic counseling.

20.20(21) Failure to report disciplinary action. Failure to report a license revocation, suspension, or other disciplinary action taken against a licensee by a professional licensing authority of another state, an agency of the United States government, or any country, territory, or other jurisdiction, within 30 days of final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.

20.20(22) Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of genetic counseling entered into with this state, another state, the United States, an agency of the federal government, or any country, territory or other jurisdiction.

20.20(23) Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.

20.20(24) Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6.

20.20(25) Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or a drug or alcohol screening.

20.20(26) Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary proceedings under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

20.20(27) Rescinded IAB 3/11/20, effective 4/15/20.

20.20(28) Improper management of medical records. Improper management of medical records includes, but is not limited to, failure to maintain timely, accurate, and complete medical records.

20.20(29) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and rule 653—24.2(17A,147,148,272C).

20.20(30) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

20.20(31) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one has been granted.

20.20(32) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by the board staff or within the extension of time if one has been granted.

20.20(33) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D and 653—Chapter 12.

20.20(34) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee's voluntary action to avoid a hospital disciplinary action, as required by rule 653—22.5(272C).

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4979C, IAB 3/11/20, effective 4/15/20; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—20.21(272C) Complaints and investigations. 653—Chapter 24 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.22(272C) Contested case proceedings. 653—Chapter 25 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.23(272C) Reinstatement after disciplinary action. 653—Chapter 26 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.24(148H,272C) Surrender of license to the board.

20.24(1) A genetic counselor whose license is suspended or revoked or whose surrender of license with or without prejudice has been accepted by the board shall promptly surrender the original license to the board.

20.24(2) A genetic counselor whose ABGC certification has lapsed or whose certification has been revoked by the ABGC shall surrender the genetic counselor's license to the board.

20.24(3) A provisional licensee who loses active candidate status with the ABGC must immediately cease the practice of genetic counseling until the provisional licensee obtains an extension of the provisional license or obtains a new provisional license.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.25(147,148H,272C) Waiver prohibited. Fees in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code chapters 147, 148, 148H, and 272C.

[Filed ARC 4339C (Notice ARC 4095C, IAB 10/24/18), IAB 3/13/19, effective 4/17/19]¹

[Filed Emergency ARC 4468C, IAB 6/5/19, effective 5/15/19]

[Filed ARC 4728C (Notice ARC 4477C, IAB 6/5/19), IAB 10/23/19, effective 11/27/19]

[Filed ARC 4979C (Notice ARC 4806C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]

[Filed ARC 5600C (Notice ARC 5370C, IAB 12/30/20), IAB 5/5/21, effective 6/9/21]

¹ April 17, 2019, effective date of Chapter 20 [ARC 4339C] delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 2019; delay lifted at the meeting held May 14, 2019.

CHAPTER 21
PHYSICIAN SUPERVISION OF A PHYSICIAN ASSISTANT

653—21.1(148,272C) Ineligibility determinants. A physician with an active permanent, special, or temporary Iowa license who is actively engaged in the practice of medicine in Iowa may supervise a physician assistant. A physician is ineligible to supervise a physician assistant for any of the following reasons:

21.1(1) The physician does not hold an active, permanent, special or temporary Iowa medical license.

21.1(2) The physician is subject to a disciplinary order of the board that restricts or rescinds the physician's authority to supervise a physician assistant. The physician may supervise a physician assistant to the extent that the order allows.

21.1(3) The physician does not have a written supervisory agreement in place with each physician assistant supervised by the physician.

21.1(4) The physician is already supervising five physician assistants.
[ARC 3264C, IAB 8/16/17, effective 9/20/17; ARC 5252C, IAB 11/4/20, effective 12/9/20]

653—21.2(148,272C) Exemptions from this chapter. This chapter shall not apply to the following:

21.2(1) A physician working in a federal facility or under federal authority when the provisions of this chapter conflict with federal regulations.

21.2(2) A physician who supervises a physician assistant providing medical care created by an emergency or a state or local disaster pursuant to Iowa Code section 148C.4.

653—21.3(148) Board notification. A physician who supervises a physician assistant shall notify the board of the supervisory relationship within 60 days of the provision of initial supervision and at the time of the physician's license renewal.

[ARC 3264C, IAB 8/16/17, effective 9/20/17]

653—21.4(148,272C) Supervisory agreements.

21.4(1) A physician who supervises a physician assistant shall establish a written supervisory agreement prior to supervising a physician assistant. A sample supervisory agreement form is available from the board. The purpose of the supervisory agreement is to define the nature and extent of the supervisory relationship and the expectations of each party. The supervisory agreement shall take into account the physician assistant's demonstrated skills, training and experience, proximity of the supervising physician to the physician assistant, and the nature and scope of the medical practice. The supervising physician shall maintain a copy of the supervisory agreement and provide a copy of the agreement to the board upon request. The supervisory agreement shall, at a minimum, address the following provisions.

a. Review of requirements. The supervising physician and the physician assistant shall review all of the requirements of physician assistant licensure, practice, supervision, and delegation of medical services as set forth in Iowa Code section 148.13 and chapter 148C, these rules, and 645—Chapters 326 to 329.

b. Assessment of education, training, skills, and experience. Each supervising physician shall assess the education, training, skills, and relevant experience of the physician assistant prior to providing supervision. Each supervising physician and physician assistant shall ensure that the other party has the appropriate education, training, skills, and relevant experience necessary to successfully collaborate on patient care delivered by the team. The method for assessing and providing feedback regarding the physician assistant's education, training, skills, and experience shall be reflected in the supervisory agreement.

21.4(2) The supervisory agreement between the physician assistant and the physician shall address all of the following:

a. The medical services the supervising physician delegates to the physician assistant. The medical services and medical tasks delegated to and provided by the physician assistant shall be in

compliance with 645—subrule 327.1(1). All delegated medical services shall be within the scope of practice of the supervising physician and the physician assistant.

b. Methods for communication between the physician assistant and the physician and whether the physician assistant practices at the same site or a remote site. Each supervising physician and physician assistant shall conduct ongoing discussions and evaluation of the supervisory agreement, including supervision; expectations for both parties; assessment of education, training, skills, and relevant experience; review of delegated services; review of the medical services provided by the physician assistant; and the types of cases and situations when the supervising physician expects to be consulted.

(1) The plan for completing and documenting chart reviews. A licensed physician within the same facility or health care system as the physician assistant shall conduct an ongoing review of a representative sample of the physician assistant's patient charts encompassing the scope of the physician assistant's practice. The finding of the review shall be discussed with the physician assistant in a manner determined by the practice in consultation with the physician assistant's primary supervising physician.

(2) Remote medical site. "Remote medical site" means a medical clinic for ambulatory patients which is more than 30 miles away from the main practice location of the supervising physician and in which the supervising physician is present less than 50 percent of the time when the remote medical site is open. "Remote medical site" will not apply to nursing homes, patient homes, hospital outpatient departments, outreach clinics, or any location at which medical care is incidentally provided (e.g., diet center, free clinic, site for athletic physicals, jail facility). The supervisory agreement shall include a provision which ensures that the supervising physician visits the remote medical site, or communicates with a physician assistant at the remote medical site via electronic communications, at least every two weeks to provide additional medical direction, medical services and consultation specific to the medical services provided at the remote medical site. For purposes of this subparagraph, communication may consist of, but shall not be limited to, in-person meetings or two-way, interactive communication directly between the supervising physician and the physician assistant via the telephone, secure messaging, electronic mail, or chart review. The board shall only grant a waiver of this provision if substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in this subparagraph.

(3) The expectations and plan for alternate supervision. The supervising physician will ensure that the alternate supervising physician is available for a timely consultation and will ensure that the physician assistant is notified of the means by which to reach the alternate supervising physician.

[ARC 3264C, IAB 8/16/17, effective 9/20/17; ARC 4213C, IAB 1/2/19, effective 2/6/19; ARC 5252C, IAB 11/4/20, effective 12/9/20]

653—21.5(148,272C) Grounds for discipline. A physician may be subject to disciplinary action for supervising a physician assistant in violation of these rules or the rules found in 653—Chapter 23 or 645—Chapters 326 and 327, which relate to duties and responsibilities for physician supervision of physician assistants. Grounds for discipline also include:

21.5(1) The physician supervises a physician assistant when the physician does not have sufficient training or experience to supervise a physician assistant in the area of medical practice in which a physician assistant is to be utilized.

21.5(2) A physician supervises more than five physician assistants at the same time.

21.5(3) The physician fails to ensure that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.

21.5(4) The physician fails to adequately direct and supervise a physician assistant or fails to comply with the minimum standards of supervision in accordance with this chapter, Iowa Code section 148.13 and chapter 148C, and 645—Chapters 326 to 329.

[ARC 0870C, IAB 7/24/13, effective 8/28/13; ARC 2532C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 3264C, IAB 8/16/17, effective 9/20/17]

653—21.6(148,272C) Disciplinary sanction. The board may restrict or rescind a physician's authority to supervise a physician assistant as part of a disciplinary sanction following a contested case proceeding, if the reason for the disciplinary action impacts the ability of the physician to supervise a physician

assistant. The board shall notify the board of physician assistants when it takes a disciplinary action against a physician's license that affects the physician's authority to supervise a physician assistant. [ARC 2532C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 3264C, IAB 8/16/17, effective 9/20/17]

653—21.7(148,272C) Communication with physician assistant supervisees. The physician shall notify all physician assistant supervisees within one workday upon receiving disciplinary action from the board or any other change in status that affects the physician's eligibility to supervise a physician assistant.

[ARC 2532C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 3264C, IAB 8/16/17, effective 9/20/17]

653—21.8(17A,147,148,272C) Waiver requests. Waiver requests shall be submitted in conformance with 653—Chapter 3.

[ARC 2532C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 3264C, IAB 8/16/17, effective 9/20/17; ARC 5600C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code sections 148.13 and 272C.3.

[Filed 1/4/89, Notice 11/16/88—published 1/25/89, effective 3/1/89]¹²³

[Filed 8/31/89, Notice 5/31/89—published 9/20/89, effective 10/25/89]

[Filed 2/23/96, Notice 1/3/96—published 3/13/96, effective 4/17/96]⁴

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[Filed 9/29/00, Notice 8/23/00—published 10/18/00, effective 11/22/00]

[Filed 12/4/03, Notice 8/20/03—published 12/24/03, effective 1/28/04]⁵

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[Filed ARC 0870C (Notice ARC 0692C, IAB 4/17/13), IAB 7/24/13, effective 8/28/13]

[Filed ARC 2532C (Notice ARC 2372C, IAB 1/20/16), IAB 5/11/16, effective 6/15/16]⁶

[Filed ARC 3264C (Notice ARC 3069C, IAB 5/24/17), IAB 8/16/17, effective 9/20/17]

[Filed ARC 4213C (Notice ARC 3992C, IAB 9/12/18), IAB 1/2/19, effective 2/6/19]

[Filed ARC 5252C (Notice ARC 5133C, IAB 8/12/20), IAB 11/4/20, effective 12/9/20]

[Filed ARC 5600C (Notice ARC 5370C, IAB 12/30/20), IAB 5/5/21, effective 6/9/21]

¹ Effective date of 3/1/89 delayed 70 days by Administrative Rules Review Committee at its February 13, 1989, meeting.

² Effective date of 3/1/89 delayed until adjournment of the 1990 Session of the General Assembly at its May 9, 1989, meeting.

³ Delay until adjournment of the 1990 G.A. lifted by the Administrative Rules Review Committee at its August 3, 1989, meeting which allowed the rules to become effective August 4, 1989.

⁴ Effective date of 4/17/96 delayed 70 days by the Administrative Rules Review Committee at its meeting held April 16, 1996. Effective date delayed until adjournment of the 1997 General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 1996.

⁵ Effective date of 1/28/04 delayed 70 days by the Administrative Rules Review Committee at its January 6, 2004, meeting; at its meeting held March 8, 2004, the Committee lifted the delay, effective March 9, 2004.

⁶ Amendments to ch 21 in ARC 2532C, which included the renumbering of 21.4 to 21.7 as 21.5 to 21.8 (Item 1), the adoption of new 21.4 (Item 2), and the amendment to the implementation sentence (Item 3), rescinded by 2017 Iowa Acts, House File 591, section 2, paragraph "a," on 4/12/17 and, pursuant to paragraph "b," prior language restored IAC Supplement 5/10/17.

CHAPTER 23
GROUNDS FOR DISCIPLINE
[Prior to 7/19/06, see 653—Chapter 12]

653—23.1(272C) Grounds for discipline. The board has authority to impose discipline for any violation of Iowa Code chapter 147, 148, 148E, 252J, 272C or 272D or the rules promulgated thereunder. The grounds for discipline apply to physicians and acupuncturists. This rule is not subject to waiver pursuant to 653—Chapter 3 or any other provision of law. The board may impose any of the disciplinary sanctions set forth in 653—subrule 25.25(1), including civil penalties in an amount not to exceed \$10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

23.1(1) Violating any of the grounds for the revocation or suspension of a license as listed in Iowa Code section 147.55, 148.6, 148E.8 or 272C.10.

23.1(2) Professional incompetency. Professional incompetency includes, but is not limited to, any of the following:

- a.* Willful or repeated gross malpractice;
- b.* Willful or gross negligence;
- c.* A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- d.* A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- e.* A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances;
- f.* A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery or osteopathic medicine and surgery in the state of Iowa;
- g.* Failure to meet the acceptable and prevailing standard of care when delegating or supervising medical services provided by another physician, health care practitioner, or other individual who is collaborating with or acting as an agent, associate, or employee of the physician responsible for the patient's care, whether or not injury results.

23.1(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes, but is not limited to, the failure of a physician to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances in this state, or when a physician is unable to practice medicine with reasonable skill and safety as a result of a mental or physical impairment or chemical abuse.

23.1(4) Unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or 653—13.7(147,148,272C) or 653—13.20(147,148) as interpreted by the board.

23.1(5) Sexual misconduct. Engaging in sexual misconduct includes, but is not limited to, engaging in conduct set out at 653—subrule 13.7(4) or 13.7(6) as interpreted by the board.

23.1(6) Substance abuse. Substance abuse includes, but is not limited to, excessive use of alcohol, drugs, narcotics, chemicals or other substances in a manner which may impair a licensee's ability to practice the profession with reasonable skill and safety.

23.1(7) Indiscriminately or promiscuously prescribing, administering or dispensing any drug for other than lawful purpose includes, but is not limited to:

- a.* Self-prescribing or self-dispensing controlled substances.
- b.* Prescribing or dispensing controlled substances to members of the licensee's immediate family.

(1) Prescribing or dispensing controlled substances to members of the licensee's immediate family is allowable for an acute condition or on an emergency basis when the licensee conducts an examination, establishes a medical record, and maintains proper documentation.

(2) Immediate family includes the physician's spouse or domestic partner and either of the physician's, spouse's, or domestic partner's parents, stepparents or grandparents; the physician's natural or adopted children or stepchildren and any child's spouse, domestic partner or children; the siblings of the physician or the physician's spouse or domestic partner and the sibling's spouse or domestic partner; or anyone else living with the physician.

23.1(8) Physical or mental impairment. Physical or mental impairment includes, but is not limited to, any physical, neurological or mental condition which may impair a physician's ability to practice the profession with reasonable skill and safety. Being adjudged mentally incompetent by a court of competent jurisdiction shall automatically suspend a license for the duration of the license unless the board orders otherwise.

23.1(9) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory or other jurisdiction, as defined in Iowa Code section 148.6(2) "b."

23.1(10) Violation of the laws or rules governing the practice of medicine or acupuncture of this state, another state, the United States, or any country, territory or other jurisdiction. Violation of the laws or rules governing the practice of medicine includes, but is not limited to, willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148, 148E or 272C or other state or federal laws or rules governing the practice of medicine.

23.1(11) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

23.1(12) Violation of an initial agreement or health contract entered into with the Iowa physician health program (IPHP).

23.1(13) Failure to comply with an evaluation order. Failure to comply with an order of the board requiring a licensee to submit to evaluation under Iowa Code section 148.6(2) "h" or 272C.9(1).

23.1(14) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession includes, but is not limited to, an intentional perversion of the truth, either orally or in writing, by a physician in the practice of medicine and surgery or osteopathic medicine and surgery or by an acupuncturist.

23.1(15) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice acupuncture, medicine and surgery, or osteopathic medicine and surgery in this state, and includes false representations of material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for a license in this state.

23.1(16) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a licensee's having made misleading, deceptive or untrue representations as to the acupuncturist's or physician's competency to perform professional services for which the licensee is not qualified to perform by education, training or experience.

23.1(17) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making known to the public information or intention which is false, deceptive, misleading or promoted through fraud or misrepresentation and includes statements which may consist of, but are not limited to:

- a. Inflated or unjustified claims which lead to expectations of favorable results;
- b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty of practice for which the licensee is not qualified;
- c. Representations that are likely to cause the average person to misunderstand; or

- d.* Extravagant claims or claims of extraordinary skills not recognized by the medical profession.
- 23.1(18)** Obtaining any fee by fraud or misrepresentation.
- 23.1(19)** Acceptance of remuneration for referral of a patient to other health professionals in violation of the law or medical ethics.
- 23.1(20)** Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.
- 23.1(21)** Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery.
- 23.1(22)** Failure to report disciplinary action. Failure to report a license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state, an agency of the United States government, or any country, territory or other jurisdiction within 30 days of the final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report shall be expunged from the records of the board.
- 23.1(23)** Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery entered into with this state, another state, the United States, an agency of the federal government, or any country, territory or other jurisdiction.
- 23.1(24)** Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.
- 23.1(25)** Failure to file the reports required by 653—22.2(272C) within 30 days concerning wrongful acts or omissions committed by another licensee.
- 23.1(26)** Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6 and 653—subrule 24.2(6) and rule 653—25.12(17A).
- 23.1(27)** Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or drug or alcohol screening.
- 23.1(28)** The inappropriate use of a rubber stamp to affix a signature to a prescription. A person who is unable, due to a disability, to make a written signature or mark, however, may substitute in lieu of a signature a rubber stamp which is adopted by the disabled person for all purposes requiring a signature and which is affixed by the disabled person or affixed by another person upon the request of the disabled person and in the presence of the disabled person.
- 23.1(29)** Maintaining any presigned prescription which is intended to be completed and issued at a later time.
- 23.1(30)** Failure to comply with the recommendations issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures, or with the protocols established pursuant to Iowa Code chapter 139A.
- 23.1(31)** Failure by a physician with HIV or HBV who practices in a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by a hospital under Iowa Code section 139A.22(1) or to an expert review panel established by the department of public health under Iowa Code section 139A.22(3).
- 23.1(32)** Failure by a physician with HIV or HBV who practices outside a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by the department of public health under Iowa Code section 139A.22(3).
- 23.1(33)** Failure by a physician subject to the reporting requirements of 23.1(31) and 23.1(32) to comply with the recommendations of an expert review panel established by the department of public health pursuant to Iowa Code section 139A.22(3), with hospital protocols established pursuant to Iowa Code section 139A.22(1), or with health care facility procedures established pursuant to Iowa Code section 139A.22(2).
- 23.1(34)** Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary

proceedings initiated under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

23.1(35) Rescinded IAB 3/11/20, effective 4/15/20.

23.1(36) Improper management of medical records. Improper management of medical records includes, but is not limited to, failure to maintain timely, accurate, and complete medical records.

23.1(37) Failure to transfer medical records to another physician in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient.

23.1(38) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and 653—24.2(17A,147,148,272C).

23.1(39) Failure to comply with the direct billing requirements for anatomic pathology services established in Iowa Code Supplement section 147.106.

23.1(40) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

23.1(41) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(42) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(43) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to 2008 Iowa Acts, Senate File 2428, division II, and 653—Chapter 12.

23.1(44) Voluntary agreements. The board may take disciplinary action against a physician if that physician has entered into a voluntary agreement to restrict the practice of medicine in another state, district, territory, or country.

a. The board will use the following criteria to determine if a physician has entered into a voluntary agreement within the meaning of Iowa Code section 148.12 and this rule.

(1) The voluntary agreement was signed during or at the conclusion of a disciplinary investigation, or to prevent a matter from proceeding to a disciplinary investigation.

(2) The agreement includes any or all of the following:

1. Education or testing that is beyond the jurisdiction's usual requirement for a license or license renewal.

2. An assignment beyond what is required for license renewal or regular practice, e.g., adoption of a protocol, use of a chaperone, completion of specified continuing education, or completion of a writing assignment.

3. A prohibition or limitation on practice privileges, e.g., a restriction on prescribing or administering controlled substances.

4. Compliance with an educational plan.

5. A requirement that surveys or reviews of patients or patient records be conducted.

6. A practice monitoring requirement.

7. A special notification requirement for a change of address.

8. Payment that is not routinely required of all physicians in that jurisdiction, such as a civil penalty, fine, or reimbursement of any expenses.

9. Any other activity or requirements imposed by the board that are beyond the usual licensure requirements for obtaining, renewing, or reinstating a license in that jurisdiction.

b. A certified copy of the voluntary agreement shall be considered prima facie evidence.

23.1(45) Performing or attempting to perform any surgical or invasive procedure on the wrong patient or at the wrong anatomical site or performing the wrong surgical procedure on a patient.

23.1(46) Violation of the standards of practice for medical directors who delegate and supervise medical aesthetic services performed by nonphysician persons at a medical spa as set out at rule 653—13.8(148,272C).

23.1(47) Failure to provide the board, within 14 days of a request by the board as set out at 653—paragraph 13.8(5)“l,” written verification of the education and training of all nonphysician persons who perform medical aesthetic services at a medical spa.

23.1(48) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee’s voluntary action to avoid a hospital investigation or hospital disciplinary action, as required by rule 653—22.5(272C).

This rule is intended to implement Iowa Code chapters 17A, 147, 148 and 272C and 2008 Iowa Acts, Senate File 2428, division II.

[ARC 8525B, IAB 2/10/10, effective 3/17/10; ARC 9088B, IAB 9/22/10, effective 10/27/10; ARC 9598B, IAB 7/13/11, effective 8/17/11; ARC 0533C, IAB 12/26/12, effective 1/30/13; ARC 4979C, IAB 3/11/20, effective 4/15/20; ARC 5600C, IAB 5/5/21, effective 6/9/21]

653—23.2(272C) Student loan default or delinquency—prohibited grounds for discipline. The board shall not suspend or revoke a license issued by the board to a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

This rule is intended to implement Iowa Code section 272C.4(10).

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[◇] Two or more ARCs

¹ Effective date of subrule 135.204(10) [renumbered 12/4(10), IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from November 2, 1983.

² Effective date of rules 135.206, 135.207 and 135.208 [renumbered 12.6, 12.7 and 12.8, IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from December 12, 1984. Delay lifted by committee on January 9, 1985.

PUBLIC SAFETY DEPARTMENT[661]

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

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661—53.1(80) Fire service training bureau. There is established within the state fire marshal division a fire service training bureau, with responsibility for instructing the general public and fire protection personnel throughout the state, providing service to public and private fire departments in the state, conducting research in the methods of maintaining and improving fire and other emergency services education consistent with the needs of Iowa communities, and performing any other functions assigned to the bureau by the state fire marshal in consultation with the state fire service and emergency response council.

[ARC 4641C, IAB 8/28/19, effective 10/2/19]

661—53.2(80) Programs, services, and fees.

53.2(1) Courses and registration fees. Current course offerings and associated registration and other related course fees of the fire service training bureau are available in electronic format via the fire service training bureau web page, and hard copy upon request. Current course registration fees and any other fees related to participation in courses shall be listed in electronic format via the fire service training bureau web page, and hard copy upon request, and shall be effective until superseded by publication of a later edition of the web page and document. Prospective students should inquire of the fire service training bureau as to the date of most recent publication of any courses, services, and fees prior to submitting registration and other fees for a course.

53.2(2) Conferences and fees. Upcoming conferences offered by the fire service training bureau are listed in electronic format via the fire service training bureau web page, and hard copy upon request. Conference registration fees and any other fees related to attendance at conferences shall be listed in electronic format via the fire service training bureau web page, and hard copy upon request, and shall be effective until superseded by publication of a later edition of the web page and document. Prospective students should inquire of the fire service training bureau as to the date of most recent publication of any conferences and associated fees prior to submitting registration fees or any other fees related to attendance at a conference.

53.2(3) Publications and materials; fees. All publications and materials currently offered for sale by the fire service training bureau are listed in electronic format via the fire service training bureau web page, and hard copy upon request. Current prices of publications shall be listed in electronic format via the fire service training bureau web page, and hard copy upon request, and shall be effective until superseded by publication of a later edition of the web page and document. Persons wishing to purchase publications or materials should inquire of the fire service training bureau as to the date of most recent publication and associated fees prior to submitting payment for publications or materials.

53.2(4) Other services and tuition fees. Services other than courses, conferences, and firefighter certification offered by the fire service training bureau are listed in electronic format via the fire service training bureau web page, and hard copy upon request. Current fees for these services shall be listed in electronic format via the fire service training bureau web page, and hard copy upon request, and shall be effective until superseded by publication of a later edition of the web page and document. Prospective clients for these services should inquire of the fire service training bureau as to the date of most recent publication of services and fees prior to submitting a request for or payment for any service.

[ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5603C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code section 80.5.

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[Filed ARC 4641C (Notice ARC 4522C, IAB 7/3/19), IAB 8/28/19, effective 10/2/19]

[Filed ARC 5603C (Notice ARC 5501C, IAB 3/10/21), IAB 5/5/21, effective 6/9/21]

CHAPTER 251
FIREFIGHTER TRAINING AND CERTIFICATION
[Prior to 9/29/04, see 661—Ch 54]

661—251.1(100B) Definitions. The following definitions apply to rules 661—251.1(100B) to 661—251.204(100B):

“*Emergency incident*” means any incident involving a fire or other hazardous situation to which personnel of a fire department respond.

“*NFPA*” means the National Fire Protection Association.

“*Structural firefighting*” means firefighting in a hazardous environment which requires the use of self-contained breathing apparatus.

[ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.2 to 251.100 Reserved.

MINIMUM TRAINING STANDARDS

661—251.101(100B) Minimum training standard. Any member of a fire department shall have completed the training requirements identified in the job performance requirements for the fire fighter I classification in NFPA 1001, Standard for Fire Fighter Professional Qualifications, based on the current edition adopted by the fire service training bureau, prior to the member’s engaging in structural firefighting. Each fire department shall identify its members who are or will be engaged in structural firefighting and shall ensure that any member engaged in structural firefighting has completed the training requirements specified in this rule prior to the member’s engaging in structural firefighting.

NOTE: A firefighter is not required to be certified to meet this requirement. Training to meet this requirement may be provided by the fire service training bureau, a community college, a regional fire training facility, a local fire department, or any combination thereof.

EXCEPTION 1: A firefighter who received training which complied with the job performance requirements for the fire fighter I classification contained in an earlier edition of NFPA 1001 shall be deemed to have met this requirement, provided that records documenting the training are maintained in accordance with rule 661—251.104(100B).

EXCEPTION 2: The chief or the training officer of any fire department may apply to the state fire marshal by June 1 of any year for an extension of the deadline to meet the training requirement for members of the department engaged in structural firefighting. Any such extension shall be for one year and may be renewed annually upon application. An extension shall be granted only if the department has requested training required under this rule, with training costs to be offset through funding from the firefighting training and equipment fund, pursuant to 661—Chapter 259, and funds to offset the cost of the training have not been available or have been inadequate to fully offset the cost of the training. The extension may be for all or some of the firefighters in the department. The application shall be in a form specified by the state fire marshal and shall list by name each firefighter for whom an extension is requested. The extension, if granted, shall list by name the firefighters to whom the extension applies and shall apply only to those listed.

[ARC 9928B, IAB 12/14/11, effective 2/1/12; ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.102(100B) Other training. Any member of a fire department who serves in a capacity other than structural firefighting at an emergency incident shall have received training based on the duties the member might perform at an emergency incident. Training to meet this requirement may be provided by the fire service training bureau, a community college, a regional fire training facility, or a local fire department, or any combination thereof.

[ARC 9928B, IAB 12/14/11, effective 2/1/12; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.103(100B) Continuing training. Fire department members shall participate in at least 24 hours of continuing training annually, which may include, but is not limited to, the following subject matter areas:

1. Personal protective equipment and respiratory protection.
2. Structural firefighting techniques, including standard operating policies and procedures or standard operating guidelines.
3. Ground ladders.
4. Hose and hose appliances.
5. Ventilation.
6. Forcible entry.
7. Search and rescue techniques.
8. Firefighter safety.
9. National Incident Management System or Incident Command System.
10. Emergency vehicle driver-operator.
11. Hazardous materials first responder—operations level.
12. Emergency medical service (EMS) training.
13. Additional training based on standard operating policies and procedures or standard operating guidelines.
14. Occupational Safety and Health Administration (OSHA)-related training, such as blood-borne pathogen protection.
15. Specialty training such as confined space entry, vehicle extrication, rescue techniques, wildland or agricultural firefighting techniques.
16. Emergency response to terrorism.
17. Any other training designed to meet local training needs.

NOTE: Training to meet this requirement may be provided by the fire service training bureau, a community college, a regional fire training facility, or a local fire department, or any combination thereof. [ARC 9928B, IAB 12/14/11, effective 2/1/12; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.104(100B) Record keeping. Each fire department shall maintain training records for each individual member of the department who participates in emergency incidents. These training records shall identify, for all training completed by the individual firefighter, the person or persons who provided the training, the dates during which the training was completed, the location or locations where the training was delivered, and a description of the content of the training. [ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.105 to 251.200 Reserved.

FIREFIGHTER CERTIFICATION

661—251.201(100B) Firefighter certification and accreditation program. There is established within the fire service training bureau of the state fire marshal division a firefighter certification program for the state of Iowa, which shall be known as the certification and accreditation program. The certification and accreditation program is accredited by the National Board on Fire Service Professional Qualifications (PROBOARD) and the International Fire Service Accreditation Congress (IFSAC) to certify fire service personnel to accepted national standards. All certifications issued by the certification and accreditation program shall be based upon nationally accepted standards.

NOTE 1: Participation in the certification and accreditation program is voluntary, and state law does not require certification to work or volunteer as a firefighter in Iowa. However, some fire departments within the state require certification for continued employment or promotion. Inquiries regarding such requirements should be directed to the hiring or employing department.

NOTE 2: Inquiries and requests regarding the certification and accreditation program should be directed to the fire service training bureau.

251.201(1) Eligibility. Any person seeking certification through the certification and accreditation program shall be a current member of a fire, emergency, or rescue organization within the state of Iowa and shall be at least 18 years of age.

EXCEPTION: Persons not meeting the requirement of membership in a fire, emergency, or rescue organization may be granted exceptions to this requirement on an individual basis. Individuals seeking such exceptions shall address these requests to the fire service training bureau.

251.201(2) Application. Application forms for each level of firefighter certification may be obtained from the fire service training bureau. In order to enter the certification and accreditation program, an applicant shall submit a completed application, accompanied by the required fee, to the fire service training bureau. The fee must accompany the application form, although a purchase order from a public agency or private organization may be accepted in lieu of prior payment. The application and fee shall be submitted no less than two weeks prior to the date of any examination in which the applicant wishes to participate.

[ARC 9928B, IAB 12/14/11, effective 2/1/12; ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.202(100B) Certification standards. Standards for the certification and accreditation program are based upon nationally recognized standards established by the National Fire Protection Association (NFPA). Certification at each level in the Iowa fire service certification system results in national certification.

251.202(1) Firefighter.

a. Fire fighter I. Certification as a fire fighter I is based upon the requirements for fire fighter I certification established in NFPA 1001, “Standard for Fire Fighter Professional Qualifications,” current edition adopted by the fire service training bureau.

b. Fire fighter II. Certification as a fire fighter II is based upon the requirements for fire fighter II certification established in NFPA 1001, “Standard for Fire Fighter Professional Qualifications,” current edition adopted by the fire service training bureau.

251.202(2) Driver/operator.

a. Driver/operator (pumper). Certification as a driver/operator (pumper) is based upon the requirements for fire department vehicle driver/operator (pumper) certification established in NFPA 1002, “Standard for Fire Apparatus Driver/Operator Professional Qualifications,” current edition adopted by the fire service training bureau.

b. Driver/operator (aerial). Certification as a driver/operator (aerial) is based upon the requirements for fire department vehicle driver/operator (aerial) certification established in NFPA 1002, “Standard for Fire Apparatus Driver/Operator Professional Qualifications,” current edition adopted by the fire service training bureau.

251.202(3) Fire officer.

a. Fire officer I. Certification as a fire officer I is based upon the requirements for fire officer I certification established in NFPA 1021, “Standard for Fire Officer Professional Qualifications,” current edition adopted by the fire service training bureau.

b. Fire officer II. Certification as a fire officer II is based upon the requirements for fire officer II certification established in NFPA 1021, “Standard for Fire Officer Professional Qualifications,” current edition adopted by the fire service training bureau.

251.202(4) Fire inspector. Certification as a fire inspector I is based upon the requirements for certification as a fire inspector I established in NFPA 1031, “Standard for Professional Qualifications for Fire Inspector and Plans Examiner,” current edition adopted by the fire service training bureau.

251.202(5) Fire investigator. Certification as a fire investigator is based upon the requirements for certification as a fire investigator established in NFPA 1033, “Standard for Professional Qualifications for Fire Investigator,” current edition adopted by the fire service training bureau.

251.202(6) Fire and emergency services instructor.

a. Fire and emergency services instructor I. Certification as a fire and emergency services instructor I is based upon the requirements for certification as a fire and emergency services instructor I established in NFPA 1041, “Standard for Fire and Emergency Services Instructor Professional Qualifications,” current edition adopted by the fire service training bureau.

b. Fire and emergency services instructor II. Certification as a fire and emergency services instructor II is based upon the requirements for certification as a fire and emergency services instructor

II established in NFPA 1041, “Standard for Fire and Emergency Services Instructor Professional Qualifications,” current edition adopted by the fire service training bureau.

251.202(7) Responder to hazardous materials incidents.

a. Responder to hazardous materials incidents (awareness). Prior to October 1, 2019, certification as a responder to hazardous materials incidents (awareness) is based upon the requirements for certification as a responder to hazardous materials incidents (awareness) established in NFPA 472, “Standard for Competence of Responders to Hazardous Materials Incidents/Weapons of Mass Destruction Incidents,” current edition adopted by the fire service training bureau. Beginning on October 1, 2019, certification as a responder to hazardous materials incidents (awareness) is based upon the requirements for certification as a responder to hazardous materials incidents (awareness) established in NFPA 1072, “Standard for Hazardous Materials/Weapons of Mass Destruction Emergency Response Personnel Professional Qualifications,” current edition adopted by the fire service training bureau.

b. Responder to hazardous materials incidents (operations). Prior to October 1, 2019, certification as a responder to hazardous materials incidents (operations) is based upon the requirements for certification as a responder to hazardous materials incidents (operations) established in NFPA 472, “Standard for Professional Competence of Responders to Hazardous Materials Incidents/Weapons of Mass Destruction Incidents,” current edition adopted by the fire service training bureau. Beginning on October 1, 2019, certification as a responder to hazardous materials incidents (operations) is based upon the requirements for certification as a responder to hazardous materials incidents (operations) established in NFPA 1072, “Standard for Hazardous Materials/Weapons of Mass Destruction Emergency Response Personnel Professional Qualifications,” current edition adopted by the fire service training bureau.

[ARC 8302B, IAB 11/18/09, effective 1/1/10; ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.203(100B) Fees. Current certification application fees and any other fees related to participation in the certification process shall be listed on the fire service training bureau’s web page and also within the publication Certification Procedures Guide for each level of certification, published by the fire service training bureau. The information in each guide shall be effective upon publication until superseded by publication of a later edition. Prospective candidates who are considering application for a particular level of certification should contact the fire service training bureau for the latest date of publication of the Certification Procedures Guide.

Fees may be paid by personal check made payable to Iowa Department of Public Safety—Fire Service Training Bureau, credit card, purchase order from a public agency or private organization, check or draft from a public agency or private organization, or money order. The check, credit card information, purchase order, money order or draft shall be submitted with the application.

[ARC 5604C, IAB 5/5/21, effective 6/9/21]

661—251.204(100B) Certification, denial, and revocation of certification.

251.204(1) Certification. Upon completion of the requirements for certification, the applicant’s name shall be entered into the Iowa certification database maintained by the fire service training bureau for the respective level of certification and into the certification databases maintained by the National Board on Fire Service Professional Qualifications (PROBOARD) and the International Fire Service Accreditation Congress (IFSAC). Individuals who successfully complete the certification requirements shall also receive an individualized certificate awarding national certification from the fire service training bureau, which will bear numbered seals from the PROBOARD and the IFSAC, and additional insignia from the fire service training bureau.

251.204(2) Denial of certification. Certification shall be denied to any applicant who fails to meet all of the requirements for the type of certification, who knowingly submits false information to the fire service training bureau, or who engages in fraudulent activity during the certification process.

251.204(3) Revocation. The fire service training bureau may revoke the certification of any individual who is found to have knowingly provided false information to the fire service training bureau during the certification process or to have engaged in fraudulent activity during the certification process. In addition, certification may be revoked by the fire service training bureau if an individual was found to have engaged in and been convicted of a felony-level crime, including but not limited to murder,

arson, sexual assault, physical assault, embezzlement, and crimes committed against a fire department or its respective association.

251.204(4) Appeals. Any person who is denied certification or whose certification is revoked may appeal the denial or revocation. An appeal of a denial or revocation of certification shall be made to the commissioner of public safety within 30 days of the issuance of the denial or revocation using the contested case procedures specified in rules 661—10.301(17A) through 661—10.332(17A).

[ARC 9928B, IAB 12/14/11, effective 2/1/12; ARC 4641C, IAB 8/28/19, effective 10/2/19; ARC 5604C, IAB 5/5/21, effective 6/9/21]

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REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, chapter 1245.

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CHAPTER 40
DETERMINATION OF NET INCOME
[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*, 513 US 123 (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; ARC 1101C, IAB 10/16/13, effective 11/20/13]

701—40.3(422) 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 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 161A.22.
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. County health center: Bonds issued under Iowa Code section 331.441(2) “c”(7).
8. Iowa finance authority, water pollution control works and drinking water facilities financing: Bonds issued under Iowa Code section 16.131(5).
9. Iowa finance authority, beginning farmer loan program: Bonds issued under Iowa Code section 16.64.
10. Iowa finance authority, Iowa comprehensive petroleum underground storage tank fund: Bonds issued under Iowa Code section 455G.6(14).
11. Iowa finance authority, 911 program notes and bonds: Bonds issued under Iowa Code section 34A.20(6).
12. Quad Cities interstate metropolitan authority bonds: Bonds issued under Iowa Code section 28A.24.
13. Prison infrastructure revenue bonds: Bonds issued under Iowa Code sections 12.80(3) and 16.177(8).
14. Community college residence halls and dormitories bonds: Bonds issued under Iowa Code section 260C.61.
15. Community college bond program bonds: Bonds issued under Iowa Code section 260C.71(6).
16. Interstate bridges bonds: Bonds issued under Iowa Code section 313A.36.
17. Iowa higher education loan authority: Obligations issued by the authority pursuant to Iowa Code section 261A.27.
18. Vision Iowa program: Bonds issued pursuant to Iowa Code section 12.71(8).
19. School infrastructure program bonds: Bonds issued under Iowa Code section 12.81(8).

20. Honey Creek premier destination park bonds: Bonds issued under Iowa Code section 463C.12(8).

21. Iowa utilities board and Iowa consumer advocate building project bonds: Bonds issued under Iowa Code section 12.91(9).

22. Iowa jobs program revenue bonds: Bonds issued under Iowa Code section 12.87(8).

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*, 513 US 123 (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 section 422.7.

[ARC 8605B, IAB 3/10/10, effective 4/14/10; ARC 1101C, IAB 10/16/13, effective 11/20/13; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 4309C, IAB 2/13/19, effective 3/20/19]

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 and cellulosic biofuel fuels credit. Where an individual claims the work opportunity tax credit under Section 51 of the Internal Revenue Code or the alcohol and cellulosic biofuel fuels 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 before January 1, 2012. The adjustment for the alcohol and cellulosic biofuel fuels credit is applicable for tax years beginning on or after January 1, 1980.

This rule is intended to implement 2011 Iowa Code Supplement section 422.7 as amended by 2012 Iowa Acts, Senate File 2328.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

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 701—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 701—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 701—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.

e. On or after January 1, 2016, see 701—Chapter 242 for allocation and apportionment of net income to Iowa by an out-of-state business or out-of-state employee who enters Iowa to perform disaster and emergency-related work during a disaster response period as those terms are defined in Iowa Code section 29C.24.

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.

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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 701—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 701—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:

	<u>Per Return</u>	<u>Computed NOL</u>
Income:		
Retail Sales	\$125,000	\$125,000
Interest income-federal securities	2,000	2,000
Salary	<u>12,500</u>	<u>12,500</u>
Subtotal	\$139,500	\$139,500
Deductions:		
Business	\$150,000	\$150,000
Itemized deductions	<u>1,800</u>	<u>1,800</u>
(Loss) per federal	<u>(\$ 12,300)</u>	
Computed net operating loss		<u>(\$ 12,300)</u>

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:

	<u>Per Return</u>	<u>Computed NOL</u>
Income:		
Retail sales	\$125,000	\$125,000
Salary	<u>12,500</u>	<u>12,500</u>
Subtotal	\$137,500	\$137,500
Deductions:		
Business	\$150,000	\$150,000
Federal tax deductions	3,000	2,500
Itemized deductions	<u>1,000</u>	<u>-</u>
(Loss) per return	<u>(\$ 16,500)</u>	
Computed Iowa NOL		<u>(\$ 15,000)</u>

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:

	<u>Per Return</u>	<u>Computed NOL</u>
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:

	<u>Per Return</u>	<u>Computed NOL</u>
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	<u>2,070(c)</u>	<u>1,225(d)</u>
(Loss) per return	<u>(\$ 23,070)</u>	
Computed Iowa NOL		<u>(\$ 21,725)</u>

(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)	<u>(\$20,000)</u>	<u>\$15,000</u>

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	<u>\$40,000</u>	<u>(\$13,000)</u>

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	<u>3,000</u>
Total	<u>(\$11,800)</u>

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:

<u>Average Number of Weekly Hours</u>	<u>Category</u>
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 intellectual disability, 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 2011 Iowa Code Supplement section 422.7 as amended by 2012 Iowa Acts, Senate File 2247.

[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 0337C, IAB 9/19/12, effective 10/24/12]

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:

$$\begin{array}{r} \text{Husband} \\ \$2,000 \times \frac{\$6,000}{\$9,000} = \$1,333.40 \end{array} \qquad \begin{array}{r} \text{Wife} \\ \$2,000 \times \frac{\$3,000}{\$9,000} = \$666.60 \end{array}$$

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:

$$\begin{array}{r} \text{Taxable Social Security Benefits} \\ \text{and Railroad Retirement} \\ \text{Benefits on Federal Return} \end{array} \times \frac{\begin{array}{r} \text{Total Social Security Benefit} \\ \text{Received} \end{array}}{\begin{array}{r} \text{Total Social Security Benefits and} \\ \text{Railroad Retirement Benefits} \\ \text{Received} \end{array}}$$

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.

$$\begin{array}{r} \text{Taxable Social Security Benefits} \\ \text{From Worksheet} \end{array} \times \frac{\begin{array}{r} \text{Total Social Security Benefit} \\ \text{Received by Husband (or Wife)} \end{array}}{\begin{array}{r} \text{Total Social Security Benefits} \\ \text{Received by Both Spouses} \end{array}}$$

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. Investor-type activities include the study and review of financial statements or reports on operations of the activity, preparing or compiling summaries or analyses of finances or operations of the activity for the individual’s own use, and monitoring the finances or operations of the activity in a nonmanagerial capacity.

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 material participation:

(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. Rental activity or rental business does not typically involve day-to-day involvement since gross income from this activity represents amounts paid mainly for the use of the property. Examples of qualifying involvement in operations of the property that are considered material participation activities if performed on a regular, continuous and substantial basis include advertising, interviewing potential tenants, preparing leases, collecting rent, handling security deposits, receiving questions and complaints from tenants, and performing routine maintenance.

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 operating, managing and maintaining the duplexes than Mr. Stanley, and Mr. Stanley spends more than 100 hours per year in operating, managing and 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. Taxpayers are required to provide proof of services performed and the hours attributable to those services. Detailed records should be maintained by the taxpayer, on as close to a daily basis as possible at or near the time of the performance of the activity, to verify 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. Records prepared long after the activity, in preparation of an audit or proceeding, are insufficient to establish participation in an activity.

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.

40.38(10) Sale of employer securities to an Iowa employee stock ownership plan. For tax years beginning on or after January 1, 2012, 50 percent of the net capital gain from the sale or exchange of employer securities of an Iowa corporation to a qualified Iowa employee stock ownership plan (ESOP) may be eligible for the Iowa capital gain deduction. To be eligible for the capital gain deduction, the qualified Iowa ESOP must own at least 30 percent of all outstanding employer securities issued by the Iowa corporation after completion of the transaction.

a. Definitions. The following definitions apply to this subrule:

“*Employer securities*” means the same as defined in Section 409(l) of the Internal Revenue Code. “*Employer securities*” includes common stock issued by the employer and preferred stock if the provisions of Section 409(l)(3) of the Internal Revenue Code are met.

“*Iowa corporation*” means a corporation whose commercial domicile, as defined in Iowa Code section 422.32, is in Iowa. A limited liability company is not considered an Iowa corporation.

“*Qualified Iowa ESOP*” means an employee stock ownership plan, as defined in Section 4975(e)(7) of the Internal Revenue Code, and trust that are established by an Iowa corporation for the benefit of the employees of the corporation.

b. The material participation requirements set forth in subrule 40.38(1) do not apply for the sale of employer securities to an Iowa ESOP. In addition, the holding period requirements set forth in paragraph 40.38(2)“a” do not apply for the sale of employer securities to an Iowa ESOP.

This rule is intended to implement Iowa Code section 422.7 as amended by 2012 Iowa Acts, House File 2465, division XII.

[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 0073C, IAB 4/4/12, effective 5/9/12; ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1303C, IAB 2/5/14, effective 3/12/14]

701—40.39(422) Exemption of interest from bonds or notes issued to fund the 911 emergency telephone system. Interest received on or after May 4, 1990, from bonds or notes issued by the Iowa finance authority to fund the 911 emergency telephone system is exempt from the state income tax.

This rule is intended to implement Iowa Code sections 422.7 and 477B.20.

[ARC 4309C, IAB 2/13/19, effective 3/20/19]

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 ($\$50,000 \times 20/180 = \$5,556$).

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—7.8(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; ARC 0251C, IAB 8/8/12, effective 9/12/12]

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. See rule 701—40.80(422) for the exclusion of military retirement pay for tax years beginning on or after January 1, 2014.

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; ARC 1665C, IAB 10/15/14, effective 11/19/14]

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 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 and certain other qualified participants can contribute funds on behalf of beneficiaries in accounts administered by the treasurer of state to cover qualified education expenses 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. Definitions and other information about establishing college savings Iowa accounts may be found in rules promulgated by the treasurer of state. See 781—Chapter 16.

40.53(1) *Deduction from net income for contributions made to the Iowa educational savings plan trust on behalf of beneficiaries.*

- a. 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.

- b. For tax years beginning on or after January 1, 2015, if a participant makes a contribution to the Iowa educational savings plan trust on or after January 1, but on or before the deadline for filing an Iowa individual income tax return, excluding extensions, the participant may elect to have the deduction for the contribution apply to that participant's Iowa individual income taxes for the calendar year immediately preceding the year in which the contribution was made. Once a participant has elected to apply a contribution to the calendar year immediately preceding the year in which the contribution was made, the contribution is deemed to have been made on December 31 of that previous calendar year. Once the election has been made, the deduction for that contribution may only be applied in computing the taxpayer's Iowa net income for the calendar year immediately preceding the year in which the contribution was made. Contributions made on or after January 1, but before the deadline

for filing Iowa individual income taxes, that the participant elects to have applied to the immediately preceding calendar year shall count toward the maximum contribution that may be deducted for that previous year. See paragraph 40.53(1)“c” below.

EXAMPLE: An individual makes a contribution to her Iowa educational savings plan account on April 5, 2018. The deadline for filing a 2017 Iowa income tax return is April 30, 2018. The individual elects to have the contribution apply to her 2017 individual income taxes instead of her 2018 Iowa individual income taxes. The department of revenue will consider the individual’s contribution to have been made on December 31, 2017. The individual may now claim a deduction for the contribution, up to the annual maximum deduction, on her 2017 Iowa income taxes. However, because the individual elected to have her contribution apply to her 2017 Iowa income taxes, she cannot claim the deduction for the April 5, 2018, contribution on her 2018 Iowa income tax return.

c. 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 contributed or \$2,000 as adjusted by inflation. For example, if a taxpayer made a \$5,000 contribution on behalf of a beneficiary to the Iowa educational savings plan trust 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.

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 filed the 1998 Iowa individual income tax return, the participant could 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.* The refund or withdrawal of funds is to be included in net income on a participant’s Iowa individual income tax return to the extent that contributions to the account had been deducted on prior Iowa individual income tax returns of the participant if the 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 the participant makes a withdrawal from the Iowa educational savings plan trust for purposes other than the following:

a. *Qualifying higher education withdrawals.* The payment of qualified higher education expenses as defined in Section 529(e)(3) of the Internal Revenue Code. The term “qualified higher education expenses” does not include tuition expenses related to attendance at an elementary or secondary school.

b. *Qualifying elementary and secondary tuition withdrawals.* For withdrawals made on or after January 1, 2018, the payment of tuition expenses in connection with and required for enrollment or attendance at an elementary or secondary school in Iowa which is accredited under Iowa Code section 256.11, and which adheres to the provisions of the federal Civil Rights Act of 1964 and Iowa Code chapter 216. These qualified tuition expenses shall not exceed \$10,000 per beneficiary per year. This limitation is based on the beneficiary, not the participant.

Participants are responsible for tracking the amount of qualified tuition expense payments a beneficiary may receive from other participants. If a beneficiary’s distributions exceed this annual limitation, the most recent payments are presumed to be the nonqualifying payments. By agreement amongst themselves, account holders are permitted to choose an alternative method for determining which payments are nonqualifying. An alternative method is presumed valid if, after the additions

to income required by this paragraph, the beneficiary's total qualifying tax-free withdrawals for elementary or secondary school tuition expenses do not exceed the \$10,000 limitation. However, upon request, the account holders are responsible for providing the department with adequate documentation to substantiate the method used.

c. Change in beneficiaries. A change in beneficiaries under, or transfer to another account within, the Iowa educational savings plan trust.

d. ABLE rollovers. A transfer to the Iowa ABLE savings plan trust, provided such change or transfer is permitted under Iowa Code section 12D.6(5).

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.

EXAMPLE: Beneficiary A is an elementary school student who attends an accredited elementary school located in Iowa. Participant B and participant C have each opened an Iowa educational savings plan trust account with A as the designated beneficiary. In January 2019, participant B withdraws \$6,000 from B's account to pay A's spring semester tuition. In August 2019, participant C withdraws \$6,000 from C's account to pay for A's fall semester tuition. Although neither B nor C has made a withdrawal in excess of \$10,000, that limitation is based on the beneficiary, A, who has received a total of \$12,000 in distributions in 2019. Because A's total distributions have exceeded the annual limitation on distributions related to elementary or secondary school tuition, the participants must include the \$2,000 excess in their net income. Because C's withdrawal was made after B's, the entire excess is presumed attributable to C, and therefore C must include the entire \$2,000 excess in C's Iowa net income for 2019, unless B and C can show that they agreed to an alternative method of allocating the excess amount.

This rule is intended to implement Iowa Code section 422.7.

[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 3664C, IAB 2/28/18, effective 4/4/18; ARC 4516C, IAB 6/19/19, effective 7/24/19]

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 national guard duty or federal active 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 2011 Iowa Code Supplement section 422.7 as amended by 2012 Iowa Acts, Senate File 2097.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

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. Rescinded ARC 1137C, IAB 10/30/13, effective 12/4/13.

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, 2014.* For tax periods beginning after December 31, 2009, but beginning before January 1, 2014, the bonus depreciation authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 111-240, Section 2022, Public Law No. 111-312, Section 401, and Public Law No. 112-240, Section 331, 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, 2014, 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, 2014, 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 2013 Iowa Acts, Senate File 106.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13]

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.

40.65(1) In general. Iowa taxpayers who elect to expense certain depreciable business assets in the year the assets were placed in service under Section 179 of the Internal Revenue Code must also expense those same assets for Iowa income tax purposes in that year. However, for certain years, the Iowa

limitations on this deduction are different from the federal limitations for the same year. This means that for some tax years, adjustments are required to determine the correct Iowa section 179 expensing deduction, as described in this rule.

40.65(2) Claiming the deduction.

a. Timing and requirement to follow federal election. A taxpayer who takes a federal section 179 deduction must also take the deduction for the same asset in the same year for Iowa purposes, except as expressly provided by Iowa law or this rule. A taxpayer who takes a federal section 179 deduction is not permitted to opt out of taking the same deduction for Iowa purposes. A taxpayer who does not take a federal section 179 deduction on a specific qualifying asset is not permitted to take a section 179 deduction for Iowa purposes on that asset.

b. Qualifying for the deduction. Whether a specific business asset qualifies for a section 179 deduction is determined by the Internal Revenue Code (Title 26, U.S. Code) and applicable federal regulations for both federal and Iowa purposes.

c. Amount of the Iowa deduction. Generally, the Iowa deduction must equal the amount of the federal deduction taken for the same asset in the same year, subject to special Iowa limitations. The following chart provides a comparison of the Iowa and federal section 179 dollar limitations and reduction limitations. See rule 701—53.23(422) for the section 179 rules applicable to corporations (both C and S corporations) and other entities subject to the corporate income tax, and see rule 701—59.24(422) for the section 179 rules applicable to financial institutions subject to the franchise tax.

Section 179 Deduction Allowances Under Federal and Iowa Law				
Tax Year	Federal		Iowa	
	Dollar Limitation	Reduction Limitation	Dollar Limitation	Reduction Limitation
2003	\$ 100,000	\$ 400,000	\$ 100,000	\$ 400,000
2004	102,000	410,000	102,000	410,000
2005	105,000	420,000	105,000	420,000
2006	108,000	430,000	108,000	430,000
2007	125,000	500,000	125,000	500,000
2008	250,000	800,000	250,000	800,000
2009	250,000	800,000	133,000	530,000
2010	500,000	2,000,000	500,000	2,000,000
2011	500,000	2,000,000	500,000	2,000,000
2012	500,000	2,000,000	500,000	2,000,000
2013	500,000	2,000,000	500,000	2,000,000
2014	500,000	2,000,000	500,000	2,000,000
2015	500,000	2,000,000	500,000	2,000,000
2016	500,000	2,010,000	25,000	200,000
2017	510,000	2,030,000	25,000	200,000
2018	1,000,000	2,500,000	70,000	280,000
2019	1,020,000	2,550,000	100,000	400,000
2020 and later	Iowa limitations are the same as federal			

d. Reduction. Both the federal and the Iowa deductions for section 179 assets are reduced (phased out dollar for dollar) for taxpayers whose total section 179 assets placed in service during a given year cost more than the amount specified (reduction limitation) for that year. Like the deduction limitation, the Iowa and federal reduction limitations are different for certain years. See paragraph 40.65(2) “c” for applicable limitations.

EXAMPLE: Taxpayer purchases \$400,000 worth of qualifying section 179 assets and places all of them in service in 2018. Taxpayer claims a section 179 deduction of \$400,000 for the full cost of the assets on the 2018 federal return. The Iowa section 179 deduction for 2018 is phased out dollar for

dollar by the amount of section 179 assets placed in service in excess of \$280,000. This means that, for 2018, the Iowa deduction is fully phased out if the taxpayer placed in service section 179 assets that cost, in total, more than \$350,000. Since the cost of the qualifying assets in this example exceeds the Iowa section 179 phase-out limit, the taxpayer cannot claim any section 179 deduction on the Iowa return. However, the taxpayer may depreciate the entire cost of the assets for Iowa purposes.

e. Amounts in excess of the Iowa limits.

(1) Recovering the excess. Due to the differences between the Iowa and federal limitations for certain years, taxpayers may have a federal section 179 deduction that exceeds the amount allowed for Iowa purposes. This excess amount is handled in different ways depending on the source of the deduction.

1. Assets placed in service by the taxpayer or entity reporting the deduction. The cost of any section 179 assets placed in service by the taxpayer in excess of the Iowa limitation for a given year may be recovered through regular depreciation under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). The Iowa section 179 and depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa and federal law are calculated and tracked on forms made available on the department's website.

EXAMPLE: Taxpayer purchases a \$100,000 piece of equipment and places it in service in 2018. Taxpayer claims a section 179 deduction of \$100,000 for the full cost of the equipment on the 2018 federal return. Taxpayer is also required to claim a section 179 deduction of \$70,000 on the 2018 Iowa return (the full amount of the federal deduction up to the Iowa limit). The taxpayer can depreciate the remaining \$30,000 cost of the equipment for Iowa purposes.

2. Special election for assets placed in service by a pass-through entity when the section 179 deduction is claimed by the owner of that pass-through. See subrule 40.65(3) for information on a special election available to certain owners of pass-through entities related to any section 179 deductions passed through from a partnership or other entity that, in the aggregate, exceed the Iowa limitations.

(2) Application of limitation to pass-throughs. In the case of pass-through entities, section 179 limitations apply at both the entity level and the owner level. Pass-through entities that are required to file an Iowa return and that actually place section 179 assets in service should follow 40.65(2) "e"(1)"1" to account for any assets for which the total federal section 179 deductions for a given year exceeded the Iowa limitation. Owners of pass-throughs receiving section 179 deductions from one or more pass-throughs that, in the aggregate, exceed the Iowa limitations should follow 40.65(2) "e"(1)"2."

EXAMPLE: Partner A (an individual and an Iowa resident) owns 50 percent interests in each of three partnerships: C, D, and E. Partnership C does business exclusively in Iowa, places \$200,000 worth of section 179 assets in service during tax year 2019 and claims a federal section 179 deduction for the full cost of the assets. Because C is required to file an Iowa partnership return, C is subject to the Iowa section 179 limitations for 2019 and must adjust its Iowa section 179 deduction as provided in 40.65(2) "e"(1)"1." C passes 50 percent of its section 179 deduction (\$100,000 for federal purposes, \$50,000 for Iowa purposes) through to A. A also receives \$50,000 each in section 179 deductions from D and E, for a total of \$150,000 in section 179 deductions (for Iowa purposes) in 2019. A is subject to the \$100,000 Iowa section 179 deduction limitation for 2019, but because A received total section 179 deductions from one or more pass-throughs in excess of the 2019 Iowa limitation, A is eligible for the special election referenced in 40.65(2) "e"(1)"2."

f. Income limitation. The Iowa section 179 deduction for any given year is limited to the taxpayer's income from active conduct in a trade or business in the same manner that the section 179 deduction is limited for federal purposes. If an allowable Iowa section 179 deduction exceeds the taxpayer's business income for a given year, any excess may be carried forward as described in paragraph 40.65(2) "g."

g. Carryforward. This paragraph applies only to amounts that do not exceed the Iowa section 179 deduction limitations for a given year but do exceed the taxpayer's business income for that year. As with the federal deduction, allowable Iowa section 179 deductions claimed in a given year that exceed a taxpayer's business income may be carried forward and claimed in future years. This carryforward, if any, is calculated using only amounts up to the Iowa limit. Any federal section 179 deduction the

taxpayer claimed in excess of the Iowa limit is not an Iowa section 179 deduction and therefore is not eligible for the carryforward described in this paragraph. Such amounts must instead be recovered as described in paragraph 40.65(2)“e,” or in subrule 40.65(3) for taxpayers receiving the deduction from one or more pass-through entities and making the special election as described in that subrule.

EXAMPLE: Taxpayer purchases a \$100,000 piece of equipment and places it in service in 2019. Taxpayer claims a section 179 deduction of \$100,000 for the full cost of the equipment on the 2019 federal return. Taxpayer is also required to claim a section 179 deduction of \$100,000 on the 2019 Iowa return (because the federal deduction is equal to the Iowa limit for the year, the Iowa and federal deductions are the same). However, the taxpayer has only \$50,000 in business income for 2019, so the allowable deduction for that year is limited to \$50,000. The remaining \$50,000 may be carried forward and applied as a section 179 deduction (subject to all limitations) in 2020, and in any future years until the amount is fully deducted.

h. Differences in basis. Iowa adjustments for differences between the Iowa and federal section 179 deduction limitations may cause the taxpayer to have a different basis in the same asset for Iowa and federal purposes. Taxpayers are required to use forms made available on the department’s website to calculate and track these differences.

40.65(3) Section 179 deduction received from a pass-through entity. In some cases, an individual or entity that receives income from one or more pass-through entities may receive a section 179 deduction in excess of the Iowa deduction limitation listed in paragraph 40.65(2)“c” for a given year. The individual or entity may be eligible for a special election with regard to that excess section 179 deduction, as described in this subrule.

a. Tax years beginning before January 1, 2018. For tax years beginning before January 1, 2018, the amount of any section 179 deduction received in excess of the Iowa deduction limitation for that year is not eligible for the special election.

b. Special election available for tax years 2018 and 2019. For tax years beginning on or after January 1, 2018, but before January 1, 2020, an individual or entity that receives a section 179 deduction from one or more pass-through entities in excess of the Iowa deduction limitation for that tax year may elect to deduct the excess in future years, as described in this subrule. See rule 701—53.23(422) for rules applicable to corporations (both C and S corporations) and other entities subject to the corporate income tax, and see rule 701—59.24(422) for rules applicable to financial institutions subject to the franchise tax.

(1) This special election applies only to section 179 deductions passed through to the individual or entity by one or more other entities.

(2) If the total Iowa section 179 deduction passed through to the individual or entity exceeds the federal section 179 deduction limitation for that year, the individual or entity may only use the amount up to the federal limitation when calculating the deduction under this election. Any amount in excess of the federal limitation shall not be deducted for Iowa purposes.

c. Section 179 assets of an individual or entity. An individual or entity that makes the special election may not claim an Iowa section 179 deduction for any assets the individual or entity placed in service during the same year but must instead depreciate such assets using the modified accelerated cost recovery system (MACRS) without regard to bonus depreciation under Section 168(k) of the Internal Revenue Code. To the extent the individual or entity claimed a federal section 179 deduction on those assets, the Iowa depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa law and federal law are calculated and tracked on forms made available on the department’s website.

EXAMPLE: A is a sole proprietor who places in service \$20,000 worth of section 179 assets in tax year 2018 and claims the deduction for the full amount for federal purposes. A is also a partner in Partnership B, an out-of-state partnership with no Iowa filing obligation. Partnership B also places section 179 assets in service, properly claims a federal section 179 deduction, and passes a total of \$100,000 of that deduction through to A. For federal purposes, A has a total of \$120,000 in section 179 deductions. Because A has section 179 deductions from a pass-through that exceed the Iowa limitation for the year, A is eligible for the special election. A makes the special election and claims the maximum Iowa section

179 deduction of \$70,000 on the amount passed through from Partnership B. Under the special election, A will be allowed to deduct the remaining \$30,000 passed through from Partnership B over the next five years, as described in paragraph 40.65(3)“e.” However, because A made the special election, A will be required to depreciate the entire \$20,000 cost of the assets A placed in service as a sole proprietor.

d. Calculating the special election. An eligible individual or entity electing to take advantage of the special election must first add together all section 179 deductions which the individual or entity received from all relevant pass-through entities. The individual or entity must claim an aggregate Iowa section 179 deduction equal to the Iowa limit for the tax year. This amount must be subtracted from the total. Whatever remains is the amount the individual or entity will be permitted to deduct (special election deduction) in future years.

e. Special election deduction.

(1) Calculation. The remaining amount from paragraph 40.65(3)“d” must be divided into five equal shares.

(2) Claiming the special election deduction. The individual or entity may deduct one of the five shares in each of the next five years. The dollar limitations and reduction limitations on section 179 deductions do not apply to special deduction amounts allowed over the five-year period under this paragraph.

(3) Excess special deduction. The special election deduction for a given year is limited to the taxpayer’s business income for that year. Any excess may be carried forward to future years. Any amounts carried forward under this subparagraph shall be added to, and treated in the same manner as, regular Iowa section 179 deduction carryforwards as described in paragraph 40.65(2)“g.”

EXAMPLE: A is an Iowa resident who is a partner in a partnership that does not do business in Iowa. In 2019, the partnership passes through a \$600,000 federal section 179 deduction and does not recalculate the deduction for Iowa purposes, because the partnership has no obligation to file an Iowa return. A claims an Iowa section 179 deduction of \$100,000 (the 2019 Iowa limitation) and elects the five-year carryforward for the rest, meaning A will be allowed to take a \$100,000 Iowa deduction in each of the next five years.

In 2020, A is eligible for the \$100,000 deduction carried forward under the election, but A only has \$50,000 in business income. The deduction is limited to business income, so A can only use \$50,000 of the deduction in this year. However, A will be permitted to treat the excess \$50,000 as a section 179 carryforward and use it to offset business income in future years until the deduction is used up.

f. Basis. The individual’s or entity’s basis in the pass-through entity assets is adjusted by the full amount of the section 179 deduction passed through in the year that the section 179 deduction is received and is therefore the same for both Iowa and federal purposes.

g. Later tax years. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal section 179 deduction and special Iowa treatment for excess section 179 deductions received from pass-throughs is not available.

This rule is intended to implement Iowa Code section 422.7 as amended by 2019 Iowa Acts, Senate File 220.

[ARC 9103B, IAB 9/22/10, effective 10/27/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13; ARC 4142C, IAB 11/21/18, effective 12/26/18; ARC 4517C, IAB 6/19/19, effective 7/24/19]

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.

40.70(3) *Repeal of exclusion.* The exclusion of income from the sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects is repealed for tax years beginning on or after January 1, 2012. However, the exclusion is still available if the contract or agreement related to a film project was entered into on or before May 25, 2012. Assuming the same facts as those in the example in subrule 40.70(2), the taxpayer can continue to exclude \$2,500 of income on the Iowa individual income tax return for the 2012 and 2013 tax years since the contract or agreement was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40, and Iowa Code section 422.7 as amended by 2012 Iowa Acts, House File 2337, section 33.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 0398C, IAB 10/17/12, effective 11/21/12]

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, but before January 1, 2013, 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, but before January 1, 2013, 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 between July 1, 1958, and May 31, 1975, and who have not received a bonus for that service from Iowa or another state.

This rule is intended to implement 2011 Iowa Code Supplement section 422.7 as amended by 2012 Iowa Acts, Senate File 2038.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

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]

701—40.80(422) Exemption for military retirement pay. For tax years beginning on or after January 1, 2014, retirement pay received by taxpayers from the federal government for military service performed in the armed forces, armed forces reserves, or national guard is exempt from state income tax. In addition,

amounts received by a surviving spouse, former spouse, or other beneficiary of a taxpayer who served in the armed forces, armed forces reserves, or national guard under the Survivor Benefit Plan are also exempt from state income tax for tax years beginning on or after January 1, 2014. The retirement pay is only deductible to the extent it is included in the taxpayer's federal adjusted gross income.

40.80(1) Coordination with pension exclusion. The exclusion of retirement pay is in addition to the partial exclusion, provided in rule 701—40.47(422), of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses and survivors. In addition, taxpayers who receive retirement pay under federal law that combines retirement pay for both uniformed service and the federal civil service retirement system or federal employees' retirement system must prorate the retirement pay based on years of service.

EXAMPLE 1: A married individual who is 60 years of age receives \$20,000 of federal retirement pay from military service and \$30,000 in retirement pay from the Iowa public employees' retirement system during the 2014 tax year. The taxpayer can exclude \$20,000 of military retirement pay and \$12,000 as a pension exclusion under rule 701—40.47(422), for a total exclusion of \$32,000 on the taxpayer's Iowa individual income tax return for the 2014 tax year.

EXAMPLE 2: A single taxpayer who is 65 years of age receives \$60,000 as a federal pension during the 2014 tax year. The taxpayer has 20 years of military service and 27 years of civilian employment with the federal government. The military retirement pay portion is \$25,532 (20 years divided by 47 years multiplied by \$60,000). The taxpayer can exclude \$25,532 of military retirement pay and \$6,000 as a pension exclusion under rule 701—40.47(422), for a total exclusion of \$31,532 on the taxpayer's Iowa individual income tax return for the 2014 tax year.

40.80(2) Coordination with filing threshold and alternate tax. The military retirement pay is excluded from the calculation of income used to determine whether an Iowa income tax return is required to be filed pursuant to 701—subrules 39.1(1) and 39.5(10) through 39.5(13). In addition, the military retirement pay is excluded from the calculation of the special tax computation for all low-income taxpayers except single taxpayers pursuant to rule 701—39.9(422) and is excluded from the calculation of the special tax computation for taxpayers who are 65 years of age or older under rule 701—39.15(422).

40.80(3) Iowa withholding. The amount of military retirement pay is excluded from the calculation of payments used to determine whether Iowa tax should be withheld from pension and annuity payments as determined pursuant to 701—subrule 46.3(4).

This rule is intended to implement Iowa Code sections 422.5 and 422.7 as amended by 2014 Iowa Acts, Senate File 303.

[ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—40.81(422) Iowa ABLE savings plan trust. The Iowa ABLE savings plan trust was created so that individuals can contribute funds on behalf of designated beneficiaries into accounts administered by the treasurer of state. The funds contributed to the trust may be used to cover future disability-related expenses of the designated beneficiary. The funds contributed to the trust are intended to supplement, but not supplant, other benefits provided to the designated beneficiary by various federal, state, and private sources. The Iowa ABLE savings plan program is administered by the treasurer of state under the terms of Iowa Code chapter 12I. The following subrules provide details about how an individual's net income is affected by contributions to a beneficiary's account, by interest and any other earnings on a beneficiary's account, and by distributions of contributions which were previously deducted.

40.81(1) Definitions.

"Account owner" means an individual who enters into a participation agreement under Iowa Code chapter 12I for the payment of qualified disability expenses on behalf of a designated beneficiary.

"Designated beneficiary" means an individual who is a resident of this state or a resident of a contracting state and who meets the definition of "eligible individual" found in Section 529A of the Internal Revenue Code.

"Iowa ABLE savings plan trust" means a qualified ABLE program administered by the Iowa treasurer of state under the terms of Iowa Code chapter 12I.

“*Other qualified ABLE program*” refers to any qualified ABLE program administered by another state with which the Iowa treasurer of state has entered into an agreement under the terms of Iowa Code section 12I.10 (see subrule 40.81(2) below).

“*Qualified ABLE program*” means the same as defined in Section 529A of the Internal Revenue Code.

“*Qualified disability expenses*” means the same as defined in Section 529A of the Internal Revenue Code.

40.81(2) *Contracting with other states.* Iowa Code section 12I.10 allows the treasurer of state to choose to defer implementation of Iowa’s own qualified ABLE program and instead enter into an agreement with another state that already has a qualified ABLE program, to provide Iowa residents access to that state’s qualified ABLE program, provided that the other state’s program meets the qualifications set out in Iowa Code section 12I.10(1).

40.81(3) *Subtraction from net income for contributions made to the Iowa ABLE savings plan trust or other qualified ABLE program.* For tax years beginning on or after January 1, 2016, individuals can subtract from their Iowa net income the amount contributed to the Iowa ABLE savings plan trust or other qualified ABLE program on behalf of a designated beneficiary during the tax year, subject to the maximum contribution level for that year. This subtraction is not allowed for any contribution that is a transfer from an Iowa educational savings plan trust account and that was previously deducted as a contribution to the Iowa educational savings plan trust.

40.81(4) *Exclusion of interest and earnings on beneficiary accounts in the Iowa ABLE savings plan trust or other qualified ABLE program.* For tax years beginning on or after January 1, 2016, to the extent that interest or other earnings accrue on an account in the Iowa ABLE savings plan trust or other qualified ABLE program (if the account owner is an Iowa resident), the interest or other earnings are excluded for purposes of computing net income on the designated beneficiary’s Iowa individual income tax return.

40.81(5) *Addition to net income of amounts distributed to the participant from the Iowa ABLE savings plan trust or other qualified ABLE program that had previously been deducted.*

a. For tax years beginning on or after January 1, 2016, if a taxpayer, as an account owner, cancels the account owner’s account in the Iowa ABLE savings plan trust or other qualified ABLE program and receives a distribution of the funds in the account, the amount of the distribution shall be included in net income on the account owner’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 account owner or any other person as a contribution to the Iowa ABLE savings plan trust or other qualified ABLE program or as a contribution to an Iowa educational savings plan trust account.

b. For tax years beginning on or after January 1, 2016, if a taxpayer makes a withdrawal of funds previously deducted by the taxpayer or any other person from the Iowa ABLE savings plan trust or other qualified ABLE program for purposes other than the payment of qualified disability expenses, the amount of the withdrawal shall be included in net income on the taxpayer’s Iowa individual income tax return to the extent that contributions to the account had been deducted on prior Iowa individual income tax returns of the taxpayer or any other person as contributions to a qualified ABLE program or an Iowa educational savings plan trust account.

40.81(6) *Maximum contribution level.* The amount of the deduction available for an individual taxpayer each year for contributions on behalf of any one designated beneficiary to the Iowa ABLE savings plan trust or other qualified ABLE program may not exceed the maximum contribution level for that year. The maximum contribution level is set by the treasurer of state. The maximum contribution level is indexed yearly for inflation pursuant to Iowa Code section 12D.3(1).

This rule is intended to implement Iowa Code section 422.7.

[ARC 2691C, IAB 8/31/16, effective 10/5/16; ARC 4516C, IAB 6/19/19, effective 7/24/19]

701—40.82(422,541B) First-time homebuyer savings accounts.

40.82(1) *Definitions.* Definitions that apply to the first-time homebuyer savings account program may be found in Iowa Code section 541B.2.

40.82(2) *Establishing an account.*

a. Account holders.

- (1) A first-time homebuyer savings account holder must be an individual or married couple.
- (2) Any individual may establish a first-time homebuyer savings account by opening an account that meets the requirements provided in this rule.
- (3) A married couple who files a joint Iowa income tax return may establish a joint first-time homebuyer savings account by opening a joint savings account that meets the requirements provided in this rule. Married couples who file separately or separately on a combined return for Iowa income tax purposes may not establish a joint first-time homebuyer savings account.

(4) There is no limit on the number of first-time homebuyer savings accounts that any account holder may open. However, account holders are subject to other restrictions under the Iowa Code and these rules, including but not limited to the annual contribution limits and aggregate lifetime limits in paragraph 40.82(4) "c."

- (5) No account holder may open or hold more than one account for the same designated beneficiary.
- (6) The account holder may change the designated beneficiary of the account at any time.

b. Beneficiaries.

(1) In order to be a designated beneficiary of a first-time homebuyer savings account, an individual must:

1. Be a resident of Iowa, as defined in Iowa Code section 422.4,
2. Not own, either individually or jointly, any single-family or multifamily residence, and
3. Not have owned or purchased, individually or jointly, any single-family or multifamily residence at any time in the three years immediately prior to both:
 - The date on which the individual is designated the beneficiary of a first-time homebuyer savings account, and
 - The date of the qualified home purchase for which the eligible home costs are paid or reimbursed from the first-time homebuyer savings account.

(2) The designated beneficiary may also be the account holder.

(3) Each account shall have only one designated beneficiary.

(4) The account holder must designate a beneficiary, on forms provided by the department, by April 30 of the year immediately following the tax year in which the account holder opened the account.

c. Account requirements. To qualify as a first-time homebuyer savings account, the account must be:

- (1) An interest-bearing savings account meeting the qualifications for a "savings deposit" under 12 CFR 204.2(d),
- (2) At a state or federally chartered bank, savings and loan association, credit union, or trust company in Iowa, and
- (3) Used exclusively as a first-time homebuyer savings account, in compliance with the requirements of this rule.

40.82(3) Maintaining the account.

a. Contributing to the account.

(1) Any person may make cash contributions to a first-time homebuyer savings account. Cash contributions may be made by people other than the account holder or the beneficiary. However, only the account holder may claim a deduction for contributing to a first-time homebuyer savings account, as described in subrule 40.82(4).

(2) There is no limit on the amount of contributions that may be made to or retained in a first-time homebuyer savings account. However, there are restrictions on the amounts that can be deducted for Iowa income tax purposes, as described in subrule 40.82(4).

b. Documenting transactions.

(1) Annual reports. For each tax year beginning with the tax year in which the first-time homebuyer savings account is established, the account holder must submit a report to the department showing all account activity during the tax year. The report shall be included with the taxpayer's Iowa individual income tax return and must show the account number of, all deposits into, and withdrawals from, the

first-time homebuyer savings account, along with any other information required by the forms provided by the department.

(2) *Withdrawal reports.* All withdrawals must be reported, on forms provided by the department, within 90 days of the date of the withdrawal or, for withdrawals made less than 90 days before an account holder files an income tax return with the department, no later than the date the return is filed. Account holders must report both withdrawals for eligible home costs and any nonqualifying withdrawals. Any withdrawal that appears on the annual report but that is not properly reported at the time it is made shall be deemed to be a nonqualifying withdrawal that must be added back on the account holder's Iowa income tax return for the tax year in which the withdrawal was made.

(3) *Account fees.* Fees and charges for the maintenance of the account that are deducted from the account by the financial institution in which the first-time homebuyer savings account is held shall not be considered withdrawals for the purposes of the reporting requirements described in paragraph 40.82(3) "b."

c. Nonqualifying withdrawals. Funds may be withdrawn from a first-time homebuyer savings account at any time. However, once any nonqualifying withdrawal, as defined in subparagraph 40.82(5) "a"(2), is made, the account holder may no longer claim the Iowa income tax benefits related to the first-time homebuyer savings account described in subrule 40.82(4). Furthermore, any nonqualifying withdrawal shall also result in an addition to income and penalty as described in subrule 40.82(5).

d. Ten-year limitation. An account shall not remain designated a first-time homebuyer savings account for more than ten years, beginning with the year in which the account was first opened. Any funds remaining in the account on January 1 of the tenth calendar year following the year in which the account holder first opened the account shall be deemed immediately withdrawn and may be subject to Iowa income taxes and penalties as described in subrule 40.82(5). The account holder has no obligation to close the account, but as of January 1 of the tenth calendar year after the year in which the account was opened, the account will no longer be a first-time homebuyer savings account entitled to the Iowa income tax benefits described in this rule. A change in the designated beneficiary of the account does not extend the ten-year period in which the account holder may maintain a first-time homebuyer savings account; the period still runs from the year the account was first opened.

e. Exclusively first-time homebuyer account. For an account to qualify as a first-time homebuyer savings account, the account holder shall use the account exclusively as a first-time homebuyer savings account consistent with these rules.

40.82(4) Deductions.

a. Deduction for contributions. Any funds contributed to the first-time homebuyer savings account by the account holder during the tax year may be deducted from the account holder's net income on the account holder's Iowa individual income tax return for that year, subject to the limitations described in paragraph 40.82(4) "c." Although anyone may contribute funds to the first-time homebuyer savings account, only the account holder may claim the deduction, and the deduction may be claimed only for amounts the account holder personally contributed.

b. Deduction for interest. To the extent that any interest earned on the funds in a first-time homebuyer savings account is included in the account holder's Iowa income for a tax year, the amount of that interest may be deducted from the account holder's net income on the account holder's Iowa individual income tax return for that tax year, subject to the lifetime limitation described in subparagraph 40.82(4) "c"(2).

c. Limitations.

(1) *Annual limitation.* The deduction described in paragraph 40.82(4) "a" is subject to the limitations described in paragraphs "1" and "2" below. These limitations apply to the total contributions that the account holder makes to all first-time homebuyer savings accounts owned by the account holder:

1. *Joint first-time homebuyer savings account holders.* For married couples who are joint first-time homebuyer savings account holders, the deduction is limited to \$4,000 per year, adjusted annually for inflation.

2. For all other taxpayers who are first-time homebuyer savings account holders, the deduction is limited to \$2,000 per year, adjusted annually for inflation.

(2) Lifetime limitation. Account holders are subject to an aggregate lifetime limit on the deductions described in paragraphs 40.82(4)“a” and “b.” No account holder may take total deductions under this program in excess of the lifetime limitation in place for the tax year in which the account holder first opens a first-time homebuyer savings account. The applicable lifetime limit imposed upon taxpayers opening an account in a given year is calculated annually by multiplying the annual limit in effect for that year by 10.

(3) Annual publication of limitations. Each year, the department shall publish the annual contribution limit as indexed for inflation and the lifetime limit applicable to account holders who open accounts during that year.

40.82(5) Additions to income.

a. Nonqualifying withdrawals.

(1) Addition to income. If there is any nonqualifying withdrawal, as defined in subparagraph 40.82(5)“a”(2), during the tax year, the account holder must add to the account holder’s Iowa net income for that year the full amount of the nonqualifying withdrawal, to the extent such income was previously deducted under paragraph 40.82(4)“a.” Any nonqualifying withdrawal also makes the account holder ineligible to claim any further deductions described in subrule 40.82(4) in any future tax year.

(2) Nonqualifying withdrawal defined.

1. Any withdrawal from a first-time homebuyer savings account for any purpose other than the payment or reimbursement of the designated beneficiary’s eligible home costs in connection with a qualified home purchase is a nonqualifying withdrawal. A nonqualifying withdrawal includes but is not limited to a withdrawal caused by the death of the account holder and withdrawal made pursuant to garnishment, levy, bankruptcy order, or any other order. If a nonqualifying withdrawal occurs, the account holder cannot cure the nonqualifying withdrawal by returning funds to the account.

2. A withdrawal shall be presumed to be a nonqualifying withdrawal unless:

- Ownership of the qualifying home which the funds from the account are used to purchase passes to the designated beneficiary within 60 days of the date the funds are withdrawn, and
- The designated beneficiary actually occupies the home as the designated beneficiary’s primary residence within 90 days of the date the funds are withdrawn.

3. Notwithstanding subparagraph 40.82(5)“a”(2), any amount transferred between different first-time homebuyer savings accounts of the same account holder by a person other than the account holder shall not be considered a nonqualifying withdrawal.

b. Unused funds. Any amount remaining in a first-time homebuyer savings account on January 1 of the tenth calendar year after the calendar year in which the account holder first opened any first-time homebuyer savings account shall be considered immediately withdrawn. This remaining amount shall be subject to the add-back described in paragraph 40.82(5)“a.”

c. Penalties. For any amount considered a withdrawal required to be added to net income pursuant to this subrule, the account holder shall be assessed a penalty equal to 10 percent of the amount of the withdrawal. The penalty shall not apply to withdrawals made by reason of the death of the account holder or to withdrawals made pursuant to a garnishment, levy, or other order, including but not limited to an order in bankruptcy following a filing for protection under the federal Bankruptcy Code, 11 U.S.C. §101 et seq.

d. Examples.

EXAMPLE 1: Taxpayer eligible for the deduction; no addition to income or penalty from nonqualifying withdrawal. A is an individual. In 2018, A creates a new interest-bearing savings account with a financial institution. In 2018, A submits a form to the department designating the account as a first-time homebuyer savings account and designating Z, an Iowa resident who has never owned a home, as the beneficiary of the account. In tax year 2018, A contributes \$1,000 to the first-time homebuyer savings account. A contributes \$1,000 per year to the first-time homebuyer savings account during tax years 2019, 2020, and 2021. Every year, A timely submits the required annual reports and all accompanying information. In 2021, after A contributed \$1,000 to the first-time homebuyer savings

account, Z made a qualified home purchase. A withdrew the entire balance of the first-time homebuyer savings account and applied the amount to eligible home costs. Within 90 days of withdrawing the funds, A submitted the required withdrawal report and the necessary supporting documentation to the department.

Result: A is allowed to deduct from net income the amount of the contributions generated from the first-time homebuyer account, since the yearly contributions are below the annual limits. A is allowed to deduct \$1,000 each year from A's 2018, 2019, 2020, and 2021 net income. Additionally, A is allowed to deduct income from interest generated from the account each year. A does not have any addition to net income or any penalties associated with the withdrawal or usage of the funds.

EXAMPLE 2: Nonqualifying withdrawal of entire account due to voluntary withdrawal by A. Assume the same facts as Example 1. However, rather than making a qualified withdrawal, in 2021, A withdraws the entire balance of the first-time homebuyer savings account and pays for Z's college tuition.

Result: The withdrawal is a nonqualified withdrawal. Any withdrawal that is not for eligible home costs is a nonqualified withdrawal. A's nonqualified withdrawal has three results. First, the amount of the nonqualified withdrawal is added back to the account holder's net income for the tax year in which the nonqualified withdrawal occurred. In this example, A's 2021 net income would increase by the amount of the contributions that A previously deducted. (See Iowa Code section 422.7(41) "c"(1).) Second, A will be assessed a penalty equal to 10 percent of the total contributions that A previously deducted. (See Iowa Code section 422.7(41) "d.") Third, A will no longer be able to claim the first-time homebuyer deduction in any future tax years. (See Iowa Code section 422.7(41) "b"(2)(b).) A is barred from claiming the first-time homebuyer deduction in the future, even if A attempts to open a first-time homebuyer account for a different beneficiary in a different tax year.

EXAMPLE 3: Nonqualifying withdrawal of entire account by legal process. Assume the same facts as Example 1. However, rather than a qualifying withdrawal occurring, in 2021, a creditor levies the entire balance of the first-time homebuyer account in order to satisfy A's debt to the creditor.

Result: The levy is a nonqualified withdrawal. Any withdrawal, including a withdrawal that is caused by a legal process not initiated by A, that is not for a qualified home purchase is a nonqualified withdrawal. Example 3 has the same result as Example 2, except in Example 3, A does not incur a 10 percent penalty because the withdrawal was due to a levy. (See Iowa Code section 422.7(41) "d.")

EXAMPLE 4: Nonqualifying withdrawal of a partial balance of a first-time homebuyer savings account. A is an individual. In 2018, A creates a new interest-bearing savings account with a financial institution. In 2018, A submits a form with the department designating the account as a first-time homebuyer savings account and designating Z, an Iowa resident who has never owned a home, as the beneficiary of the account. In tax year 2018, A contributes \$1,000 to the first-time homebuyer savings account. A contributes \$1,000 per year to the first-time homebuyer savings account during tax years 2019, 2020, and 2021. Every year, A timely submits the required annual reports and all accompanying information. After making the \$1,000 deposit for 2021, A has a total of \$4,100 in the first-time homebuyer savings account. In 2022, A withdraws \$1,000 from the account in order to pay for personal expenses.

Result: The \$1,000 withdrawal is a nonqualifying withdrawal. A must file a withdrawal report with the department within 90 days of the withdrawal. A withdrawal report is required for both qualifying and nonqualifying withdrawals. The \$1,000 withdrawal will result in the addition of \$1,000 to A's 2022 net income. A will also be assessed a \$100 penalty. The balance of the first-time homebuyer account is \$3,100. Subject to the ten-year limitation and the other requirements of the deduction, A may use the remaining \$3,100 for Z's eligible home costs prior to January 1, 2028. If A does so, A will not have the \$3,000 added back to A's net income or face any penalties associated with the \$3,000 eligible home costs. Regardless of what occurs with the remaining \$3,100, A will be prohibited from claiming the first-time homebuyer deduction for any period after the date of the nonqualified withdrawal. This is true even if A attempts to repay the \$1,000 withdrawal or if A attempts to open any other first-time homebuyer accounts.

EXAMPLE 5: No withdrawals made within ten years of opening the account. A is an individual. In March of 2018, A creates a new interest-bearing savings account with a financial institution. A completes

all of the necessary paperwork and designates Z as the beneficiary of the account. In 2018, and in each subsequent year, A contributes \$1,000 to the first-time homebuyer savings account. On December 31, 2027, A has made a total of \$10,000 dollars in contributions to the account, has taken a deduction for each contribution, and has made no withdrawals from the account. On January 1, 2028, Z still has not purchased a qualifying home.

Result: As of January 1, 2028, the account is no longer a first-time homebuyer savings account, and the entire account balance is deemed to have been withdrawn in a nonqualifying withdrawal. A is required to report the entire \$10,000 previously deducted for contributions to the account as income in tax year 2028 and pay a \$1,000 penalty for the nonqualifying withdrawal. A can no longer open a new first-time homebuyer savings account or take any deductions for contributions made to another account under the program.

EXAMPLE 6: Divorce between taxpayers with a joint account. A and B are a married couple who file a joint Iowa income tax return. In 2018, A and B open a joint savings account and take the necessary steps to designate it as a joint first-time homebuyer savings account. In 2018, A and B contribute \$2,000 to the account and deduct the full amount on their joint Iowa income tax return for 2018. They contribute the same amount, file joint returns, and deduct the full amount in tax years 2019, 2020, and 2021. In 2022, A and B divorce. The divorce decree divides the funds in the account evenly between A and B.

Result: In this situation, when the funds from the account are distributed between A and B, the entire withdrawal is deemed to be a nonqualifying withdrawal, and A and B are jointly and severally liable for the payment of the tax and penalty due on the entire amount that they previously deducted for contributions to the first-time homebuyer savings account.

Alternative result: A and B can avoid this result by taking some steps before the divorce decree is entered. Prior to the divorce decree, A and B can each open a new first-time homebuyer savings account individually. As long as the divorce decree orders that funds from the original joint first-time homebuyer savings account be transferred to A's and B's new individual accounts, the funds may be transferred without triggering a nonqualifying withdrawal, A and B will not be subject to taxes or penalties on their previous contributions to the account, and each will still be eligible to take deductions for contributions to their new accounts, subject to the applicable limitations. In this scenario, the transfer must occur as a direct result of a court order; if A or B transfers funds themselves, the transfer is deemed to be a nonqualifying withdrawal.

Even if the funds in A and B's original joint account are successfully transferred without triggering a nonqualifying withdrawal as described above, both A and B will still be jointly and severally liable for any tax or penalty due on any nonqualifying withdrawal that either makes later, up to the amount they deducted on their joint returns prior to the divorce.

EXAMPLE 7: Death of the account holder. A is an individual. In 2018, A creates a new interest-bearing savings account with a financial institution. In 2018, A submits a form to the department designating the account as a first-time homebuyer savings account and designating Z, an Iowa resident who has never owned a home, as the beneficiary of the account. In tax year 2018, A contributes \$1,000 to the first-time homebuyer savings account. A makes \$1,000 contributions per year to the first-time homebuyer savings account during tax years 2019, 2020, and 2021. Every year, A timely submits the required annual reports and all accompanying information. In 2022, A dies without having withdrawn any funds from the account either for a qualifying home purchase for Z or for any other reason.

Result: All of the funds in the account are deemed immediately withdrawn at the time of A's death. Because this is a nonqualifying withdrawal, the \$4,000 in contributions which A previously deducted must be included as income on A's final return. However, because the reason for the deemed withdrawal was A's death, the 10 percent penalty is not included on A's final return.

This rule is intended to implement Iowa Code section 422.7 and chapter 541B.
[ARC 3770C, IAB 4/25/18, effective 5/30/18]

701—40.83(422) Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020.

40.83(1) *In general.* Public Law 115-97, Section 13303, repealed the deferral of gain or loss from exchanges of like-kind personal property for federal purposes under Section 1031 of the Internal Revenue Code. This federal repeal applies to exchanges completed after December 31, 2017, unless the taxpayer began the exchange by transferring personal property or receiving replacement personal property on or before that date. Iowa did not conform to this federal repeal for Iowa individual income tax purposes for tax periods beginning before January 1, 2019. For tax years beginning on or after January 1, 2019, but before January 1, 2020, Iowa generally conforms to the federal treatment of gain or loss from exchanges of like-kind personal property, but eligible taxpayers may elect the treatment that applied under prior federal law for Iowa purposes. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal treatment for these exchanges, and no special election is available. This rule governs exchanges of like-kind personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020. This rule does not apply to exchanges completed during any tax year beginning on or after January 1, 2020.

40.83(2) *Qualification.* Section 1031 of the Internal Revenue Code in effect on December 21, 2017, and any applicable federal regulations govern whether transactions involving the disposition and acquisition of personal property qualify for Iowa individual income tax purposes as a like-kind exchange of personal property subject to the deferral of gain or loss, and also govern the date and tax period during which an exchange is considered completed. The treatment of such transactions as a like-kind exchange for Iowa individual income tax purposes is either mandatory or permissive depending on the date the like-kind exchange is completed.

a. Like-kind exchanges completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019. Transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019, are required to be treated as a like-kind exchange for Iowa individual income tax purposes.

b. Like-kind exchanges completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020. For tax periods beginning on or after January 1, 2019, Iowa is conformed to the federal repeal of deferral of gain or loss from exchanges of like-kind personal property, so the federal and Iowa treatment of such transactions under Section 1031 of the Internal Revenue Code will generally be the same. However, transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020, may at the election of the taxpayer be treated as a like-kind exchange for Iowa individual income tax purposes. The election is made by completing the necessary worksheets and forms and making the required adjustments on the Iowa return as described in subrule 40.83(3). No special attachment or statement is required. The election only applies to the transactions involved in the like-kind exchange, and the taxpayer may elect or not elect to treat other qualifying transactions as a like-kind exchange for Iowa purposes.

40.83(3) *Calculation and Iowa adjustments.* A taxpayer required to or electing to treat qualifying transactions as a like-kind exchange for Iowa tax purposes must make certain Iowa calculations and adjustments on forms and worksheets made available on the department's website. The IA 8824 Worksheet described in this subrule need not be included with the Iowa return but must be kept with the taxpayer's records. The taxpayer is responsible for providing documentation at the department's request to substantiate a like-kind exchange under this rule.

a. Like-kind exchange calculation. The taxpayer must complete Parts I and II of the IA 8824 Worksheet to compute the Iowa recognized gain, if any, the Iowa deferred gain or loss, and the Iowa basis of the like-kind personal property received in the like-kind exchange.

EXAMPLE 1: X, a sole proprietor engaged in commercial farming and filing on a calendar-year basis, trades a tractor with a fair market value (FMV) of \$25,000 along with \$75,000 in cash to Y for a new tractor with an FMV of \$100,000. For purposes of this example it is assumed that the tractor trade occurs in 2019 and qualifies as a like-kind exchange and that X elects such treatment for Iowa individual income tax purposes under paragraph 40.83(2) "b." At the time of the trade, the adjusted basis of X's old tractor is \$0 for federal tax purposes and is \$13,680 for Iowa tax purposes. X realizes a gain for Iowa purposes

on the exchange of the old tractor in the amount of \$11,320 (\$100,000 FMV of new tractor - \$75,000 cash paid - \$13,680 Iowa adjusted basis of old tractor). Because X did not receive any cash or other property that was not like-kind, or assume any liabilities from Y, the entire amount of X's \$11,320 realized gain qualifies for deferral, so X recognizes \$0 of gain on the exchange for Iowa tax purposes. As a result, X's basis in the new tractor for Iowa tax purposes is \$88,680 (\$13,680 Iowa adjusted basis of old tractor + \$75,000 cash paid by X).

b. Iowa nonconformity adjustment.

(1) The taxpayer must complete Part III of the IA 8824 Worksheet to adjust for the difference between any recognized Iowa gain from the exchange as calculated on the IA 8824 Worksheet, Part II, and any gain or loss (including gain or loss recaptured as ordinary income) recognized on the taxpayer's federal return.

EXAMPLE 2: Assume the same facts as given in Example 1. Because the tractor trade occurred in 2019, it will not qualify as a like-kind exchange for federal tax purposes but will instead be treated as two separate transactions: a sale of the old tractor and a purchase of the new tractor. X recognizes a gain for federal tax purposes on the sale of the old tractor in the amount of \$25,000 (\$25,000 sales price of old tractor - \$0 federal adjusted basis of old tractor), the entire amount of which is recaptured as ordinary income because of prior depreciation. X reports the \$25,000 of income on the federal return. X is required to report the same \$25,000 as income on the Iowa return but is also allowed a \$25,000 subtraction on the same Iowa return because X's recognized gain for Iowa tax purposes is \$0 as calculated in Example 1. X's nonconformity adjustment of -\$25,000 must be reported on the Iowa return in the manner prescribed on the IA 8824 Worksheet.

(2) If the total recognized federal gain is reported using the installment sale method under Section 453 of the Internal Revenue Code, the total amount of any Iowa nonconformity adjustment related to that federal gain must be claimed over the same installment period, and the proportion of the total Iowa nonconformity adjustment claimed for each tax year shall equal the same proportion that the federal gain reported for that tax year bears to the total amount of federal gain that will ultimately be reported for all tax years resulting from the disposition of the personal property. The taxpayer must complete an IA 8824 Worksheet for each tax year that an Iowa nonconformity adjustment is claimed.

c. Cost recovery adjustments.

(1) The taxpayer must complete the IA 4562A to account for any differences between the federal and Iowa cost recovery deductions related to the like-kind personal property involved in the like-kind exchange, including if the taxpayer's basis in the like-kind personal property received is different for federal and Iowa purposes, or if the taxpayer claimed additional first-year depreciation or a section 179 deduction for federal purposes on the like-kind property received in the exchange. See rule 701—40.60(422) for requirements related to the disallowance of additional first-year depreciation for Iowa individual income tax purposes. See rule 701—40.65(422) for the section 179 limitations imposed under the Iowa individual income tax.

(2) Treasury Regulation §1.168(i)-6 prescribes rules related to the calculation of depreciation for certain assets involved in a like-kind exchange, but a taxpayer may elect to not have those rules apply pursuant to Treasury Regulation §1.168(i)-6(i). A taxpayer may choose to make a similar election under Treasury Regulation §1.168(i)-6(i) for Iowa tax purposes with regard to a like-kind exchange under this rule if the personal property otherwise would have qualified for such federal election notwithstanding the fact that no like-kind exchange occurred for federal purposes or the fact that no election was actually made for federal tax purposes in accordance with Treasury Regulation §1.168(i)-6(j). The election is made by calculating depreciation for Iowa tax purposes on the personal property involved in the like-kind exchange using the method described in Treasury Regulation §1.168(i)-6(i) on the timely filed Iowa return, including extensions, for the same tax year that the like-kind exchange was completed. No special attachment or statement is required.

EXAMPLE 3: Assume the same facts as given in Examples 1 and 2. X elects additional first-year depreciation on the new tractor and claims a depreciation deduction on the federal return of \$100,000 (100 percent of X's federal basis). X is required to add back the total amount of the federal depreciation on the Iowa return because Iowa does not allow additional first-year depreciation. But X is permitted

deductions for regular depreciation on the new tractor with an Iowa basis of \$88,680 (\$13,680 carryover basis from old tractor + \$75,000 excess basis from cash paid) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). See rule 701—40.60(422) for more information on the disallowance of additional first-year depreciation.

EXAMPLE 4: Assume the same facts as given in Examples 1 and 2. X elects to expense the entire cost of the new tractor under Section 179 of the Internal Revenue Code and claims a deduction on the federal return of \$100,000. X is also required to claim the section 179 deduction on the new tractor for Iowa tax purposes pursuant to subrule 40.65(2). However, the amount that represents the carryover basis from the old tractor (\$13,680) is not eligible for the deduction under Section 179(d)(3) of the Internal Revenue Code, so the cost of the new tractor that is eligible for the section 179 deduction for Iowa purposes is only \$75,000 (excess basis from cash paid). This is the amount of section 179 deduction that X must claim on the Iowa return, subject to the applicable Iowa dollar limitation and reduction limitations in rule 701—40.65(422). Because X is the taxpayer who placed the new tractor in service, X is permitted deductions for regular depreciation on the carryover basis in the new tractor (\$13,680) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k).

This rule is intended to implement Iowa Code section 422.7 as amended by 2018 Iowa Acts, chapter 1161 [Senate File 2417].

[ARC 4614C, IAB 8/14/19, effective 9/18/19]

701—40.84(422) Broadband infrastructure grant exemption.

40.84(1) *Broadband infrastructure grant exemption, generally.* For tax years beginning on or after January 1, 2019, certain qualifying communications service providers may subtract, to the extent included in income, the amount of qualifying government grants used to install broadband infrastructure that facilitates broadband service in targeted service areas at or above download and upload speeds identified by the Federal Communications Commission pursuant to Section 706 of the federal Telecommunications Act of 1996, as amended. This rule explains terms not defined in Iowa Code section 422.7.

40.84(2) *Definitions.*

“*Facilitate*” shall have the same meaning as defined in Iowa Code section 8B.1.

“*Grant*” means a transfer for a governmental purpose of money or property to a transferee that is not a related party to or an agent of the transferor. The transfer must not impose any obligation or condition to directly or indirectly repay any amount to the transferor or a related party. Obligations or conditions intended solely to assure expenditure of the transferred moneys in accordance with the governmental purpose of the transfer do not prevent a transfer from being a grant.

1. “Federal grant” means any grant issued by the United States government, including any agency or instrumentality thereof.

2. “State grant” means any grant issued by any state of the United States, the District of Columbia, or a territory or possession of the United States, including any agency or instrumentality thereof.

3. “Local grant” means any grant issued by any city, county, township, school district, or any other unit of local government, including any agency or instrumentality thereof.

40.84(3) *Limitation on certain refund claims.* For tax years beginning on or after January 1, 2019, and before January 1, 2020, refund claims resulting from this exemption must be filed prior to October 1, 2020. No refunds shall be issued for claims filed on or after that date.

This rule is intended to implement Iowa Code section 422.7.

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[◇] Two or more ARCs

CHAPTER 53
DETERMINATION OF NET INCOME
[Prior to 12/17/86, Revenue Department[730]]

701—53.1(422) Computation of net income for corporations. Net income for state purposes shall mean federal taxable income, before deduction for net operating losses, as properly computed under the Internal Revenue Code, and shall include the adjustments in 701—53.2(422) to 701—53.13(422) and 701—53.17(422) to 701—53.26(422). The remaining provisions of this rule and 701—53.14(422) to 701—53.16(422) shall also be applicable in determining net income.

In the case of a corporation which is a member of an affiliated group of corporations filing a consolidated income tax return for the taxable year for federal income tax purposes, but files a separate return for state purposes, taxable income as properly computed for federal purposes is determined as if the corporation had filed a separate return for federal income tax purposes for the taxable year and each preceding taxable year for which it was a member of an affiliated group. For purposes of this paragraph, the taxpayer's separate taxable income shall be determined as if the election provided by Section 243(b)(2) of the Internal Revenue Code had been in effect for all those years.

When a federal short period return is filed and the federal taxable income is required to be adjusted to an annual basis, the Iowa taxable income shall also be adjusted to an annual basis. The tax liability for a short period is computed by multiplying the taxable income for the short period by 12 and dividing the result by the number of months in the short period. The tax is determined on the resulting total as if it were the taxable income, and the tax computed is divided by 12 and multiplied by the number of months in the short period. This adjustment shall apply only to income attributable to business carried on within the state of Iowa.

This rule is intended to implement Iowa Code section 422.35.
[ARC 9820B, IAB 11/2/11, effective 12/7/11]

701—53.2(422) Net operating loss carrybacks and carryovers. In years beginning after December 31, 1954, net operating losses shall be allowed or allowable for Iowa corporation income tax purposes to the same extent they are allowed or allowable for federal corporation income tax purposes for the same period, provided the following adjustments are made:

53.2(1) Additions to income.

a. Refunds of federal income taxes due to net operating loss and credit carrybacks 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 or excess credit occurs. The federal refund shall still accrue for tax periods beginning on or after January 1, 2009, even though the Iowa net operating loss carryback is not allowed.

(2) Cash basis taxpayers shall reflect refunds of federal income taxes in the return for the year in which the refunds are received. The federal refund due to any net operating loss carryback for federal income tax purposes for tax years beginning on or after January 1, 2009, must still be reflected even though the Iowa net operating loss carryback is not allowed.

b. Iowa income tax deducted on the federal return for the loss year shall be reflected as an addition to income in the year of the loss.

c. Interest and dividends received in the year of the loss on federally tax-exempt securities shall be reflected as additions to income in the year of the loss.

53.2(2) Reductions of income.

a. Federal income tax paid or accrued during the year of the net operating loss shall be reflected to the extent allowed by law as an additional deduction in the year of the loss.

b. Iowa income tax refunds reported as income for federal return purposes in the loss year shall be reflected as reductions of income in the year of the loss.

c. Interest and dividends received from federal securities during the loss year shall be reflected in the year of the loss as a reduction of income.

53.2(3) If a corporation does business both within and without Iowa, it shall make adjustments reflecting the apportionment and allocation of its operating loss on the basis of business done within and without the state of Iowa after completing the provisions of subrules 53.2(1) and 53.2(2).

a. After making the adjustments to federal taxable income as provided in 53.2(1) and 53.2(2), the total net allocable income or loss shall be added to or deducted from, as the case may be, the net federal income or loss as adjusted for Iowa tax purposes. The resulting income or loss so determined shall be subject to apportionment as provided in rules 701—54.5(422), 54.6(422) and 54.7(422). The apportioned income or loss shall be added or deducted, as the case may be, to the amount of net allocable income or loss properly attributable to Iowa. This amount is the taxable income or net operating loss attributable to Iowa for that year.

b. The net operating loss attributable to Iowa, as determined in rule 701—53.2(422), shall be subject to a 3-year carryback and a 15-year carryover provision for tax years beginning prior to August 6, 1997. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa 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 15 taxable years. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa corporation income tax return filed with the department.

c. For tax years beginning after August 5, 1997, but before January 1, 2009, a net operating loss attributable to Iowa, as determined in rule 701—53.2(422), incurred in a presidentially declared disaster area by a corporation engaged in a small business or in the trade or business of farming must be carried back 3 taxable years and carried forward 20 taxable years. All other net operating losses attributable to Iowa must be carried back 2 taxable years and carried forward 20 taxable years. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa 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. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa corporation income tax return filed with the department.

d. For tax years beginning on or after January 1, 1998, but before January 1, 2009, for 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 including modifications prescribed by rule by the director, the Iowa loss from the trade or business of farming is a net operating loss which may be carried back five taxable years prior to the taxable year of the loss. 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) of the Internal Revenue Code for the two-year or three-year carryback in lieu of the five-year carryback must be attached to the Iowa return or the Form IA 1139 Application for Refund Due to the Carryback of Corporate Farming Losses, to show why the carryback was two years or three years instead of five years. However, an Iowa net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa.

When the taxpayer carries on more than one trade or business within a corporate shell or files a consolidated Iowa corporation income tax return, the income or loss from each trade or business must be combined to determine the amount of net operating loss that exists and whether it is a net operating loss from the trade or business of farming.

EXAMPLE 1. The taxpayer carries on the trade or business of farming and also the trade or business of trucking for entities outside the corporate shell. For the tax year, the taxpayer had a net operating loss

from farming of \$25,000 and net income from trucking of \$10,000 for a net operating loss for the year of \$15,000 which is a net operating loss from the trade or business of farming which may be carried back 5 tax years and forward 20 tax years.

EXAMPLE 2. The taxpayer carries on the trade or business of farming and the trade or business of construction. For the tax year, the taxpayer had income from farming of \$12,000 and a net operating loss from construction of \$45,000 for a net operating loss for the year of \$33,000 which is a net operating loss from the trade or business of construction which may be carried back 2 tax years and forward 20 tax years.

EXAMPLE 3. The taxpayer carries on the trade or business of farming and the trade or business of construction. During the tax year, the taxpayer had a net operating loss of \$18,000 from farming and a net operating loss of \$9,000 from construction for a total net operating loss of \$27,000. Of this net operating loss, \$18,000 is from farming and may be carried back 5 years and forward 20 years and \$9,000 is from construction and may be carried back 2 years and forward 20 years.

e. For tax years beginning on or after January 1, 2009, a net operating loss attributable to Iowa, as determined in rule 701—53.2(422), shall be carried forward 20 taxable years. The net operating loss cannot be carried back to a previous tax year. The federal refund due to any carryback of a federal net operating loss must still be included in income as provided in subrule 53.2(1), paragraph “a.”

53.2(4) No part of a net operating loss for a year which the corporation was not subject to the imposition of Iowa corporation 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. To be deductible, a net operating loss must be sustained from that portion of the corporation’s trade or business carried on in Iowa.

53.2(5) No part of a net operating loss may be carried back or carried forward if the carryback or carryforward would be disallowed for federal income tax purposes under Sections 172(b)(1)(E) and 172(h) of the Internal Revenue Code. This provision is effective for tax years beginning on or after January 1, 1989.

53.2(6) The carryover of Iowa net operating losses after reorganizations or mergers is limited to the same extent as the carryover of a net operating loss is limited under the provisions of Sections 381 through 386 of the Internal Revenue Code and regulations thereunder or any other section of the Internal Revenue Code or regulations thereunder. Where the taxpayer files as a part of a consolidated income tax return for federal income tax purposes, but a separate return for Iowa income tax purposes, the limitation on an Iowa net operating loss carryover must be determined as though a separate income tax return was filed for federal income tax purposes.

This rule is intended to implement Iowa Code section 422.35 as amended by 2009 Iowa Acts, Senate File 483.

[ARC 8589B, IAB 3/10/10, effective 4/14/10]

701—53.3(422) Capital loss carryback.

53.3(1) Capital losses shall be allowed or allowable for Iowa corporation income tax purposes to the same extent they are allowed or allowable for federal corporation income tax purposes. Capital loss carrybacks shall be treated as an adjustment to federal taxable income to arrive at net allocable and apportionable income.

a. For accrual-basis taxpayers the federal income tax refund shall not be accrued to the loss year but rather treated as a reduction in federal income tax paid in the carryback year.

b. Cash-basis taxpayers shall include the federal income tax refund in Iowa taxable income in the year received.

c. Where the taxpayer files a separate Iowa corporation income tax return but files as part of a federal consolidated income tax return, the portion of the federal refund due to a capital loss carryback attributable to the taxpayer shall be calculated by computing the federal tax deduction in the carryback year as follows:

Separate Company Income - Separate Company Capital Loss Carryback	×	Consolidated Federal Tax	×	50%
<hr/>				
Sum of the Incomes of Profit Companies - Sum of Separate Company Capital Loss Carrybacks to Profit Companies		after Capital Loss Carryback		

53.3(2) When the carryback year has both allocable and apportionable capital gains, the capital loss carryback shall be applied pro rata on a percentage basis of the specific gain to the total gains.

EXAMPLE: Assume a taxpayer has a 1973 capital loss carryback available of \$2000. The loss would be applied in the following manner:

1970	1970	1970	
<u>Total Capital Gain</u>	<u>Allocable Gain</u>	<u>Apportionable Gain</u>	
\$16,000	\$4,000	\$12,000	
Allocable gain	-\$4,000		
Total capital gain	-\$16,000		= ¼ or 25% of carryback to allocable gain
1970 allocable capital gain after application of loss carryback: \$4,000 less (\$2,000 × 25%) = \$3,500 net allocable capital gain.			

This rule is intended to implement Iowa Code sections 422.35 and 422.37.

701—53.4(422) Net operating and capital loss carrybacks and carryovers. If the taxpayer, for tax periods beginning prior to January 1, 2009, has both a net operating loss and a capital loss carryback to a prior tax year, the capital loss shall be carried back first and then the new operating loss offset against any remaining income.

This rule is intended to implement Iowa Code section 422.35 as amended by 2009 Iowa Acts, Senate File 483.

[ARC 8589B, IAB 3/10/10, effective 4/14/10]

701—53.5(422) Interest and dividends from federal securities. See rule 701—40.2(422) for a discussion of the exempt status of interest and dividends from federal securities.

This rule is intended to implement Iowa Code section 422.35.

701—53.6(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 taxable 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. See rule 701—40.3(422) for a listing of obligations of the state of Iowa and its political subdivisions, the interest from which is exempt from Iowa corporation income tax. For the tax treatment of interest or dividends from regulated investment companies (mutual funds) that invest in obligations of the type discussed in rule 701—40.3(422), see rule 701—40.52(422).

For tax years beginning on or after January 1, 1987, add dividends received from regulated investment companies exempt from federal tax under Section 852(b)(5) of the Internal Revenue Code and subtract the loss on the sale or exchange of a share of a regulated investment company held for six

months or less to the extent the loss was disallowed under Section 852(b)(4)(B) of the Internal Revenue Code.

For tax years beginning on or after January 1, 2001, add, to the extent not already included, income from the sale of obligations of the state of Iowa and its political subdivisions. 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 taxable income unless the law authorizing these obligations specifically exempts the income from the sale or other disposition from Iowa corporation income tax.

This rule is intended to implement Iowa Code section 422.35 as amended by 2001 Iowa Acts, House File 715.

701—53.7(422) Safe harbor leases. For tax years ending after January 1, 1981, deductions in determining federal taxable income for sale-leaseback agreements taken as a result of the application of Section 168(f)(8) of the Internal Revenue Code shall be added in determining Iowa taxable income to the extent such deductions cannot be taken under provisions of Sections 162, 163 and 167 of the Internal Revenue Code. The lessor shall add depreciation and interest expense, and the lessee shall add rental expense. When the deduction for depreciation is not allowed under a previous provision of this rule, the lessee shall be allowed a deduction for depreciation on any property involved in a sale-leaseback agreement. This depreciation shall be computed in accordance with Section 168(a) of the Internal Revenue Code. Income received as a result of a sale-leaseback agreement shall be deducted in determining Iowa taxable income. The lessee shall deduct interest income and the lessor shall deduct rent income. Each lessor and lessee corporation shall include a copy of federal Form 6793 in its Iowa corporation income tax return for the year in which a safe harbor lease is entered into.

This rule is intended to implement Iowa Code section 422.35.

701—53.8(422) Additions to federal taxable income.

53.8(1) Disallowance of private club expenses. Rescinded IAB 11/24/04, effective 12/29/04.

53.8(2) Percentage depletion. For tax years beginning on or after January 1, 1986, add the amount that percentage depletion of an oil, gas, or geothermal well computed under Section 613 of the Internal Revenue Code is in excess of cost depletion computed under Section 611 of the Internal Revenue Code.

53.8(3) Charitable contributions relating to the charitable conservation contribution tax credit. For tax years beginning on or after January 1, 2008, a taxpayer who claims a charitable conservation contribution tax credit in accordance with rule 701—52.37(422) cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes.

53.8(4) Charitable contributions relating to school tuition organizations. For tax years beginning on or after July 1, 2009, a taxpayer who claims a school tuition organization tax credit in accordance with rule 701—52.38(422) cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution to the school tuition organization for which the tax credit is claimed for Iowa tax purposes.

53.8(5) Charitable contributions relating to the endow Iowa tax credit. For tax years beginning on or after January 1, 2010, a taxpayer who claims an endow Iowa tax credit in accordance with rule 701—52.23(15E,422) cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes.

53.8(6) Charitable contributions related to the from farm to food donation tax credit. For tax years beginning on or after January 1, 2014, a taxpayer who claims a from farm to food donation tax credit in accordance with rule 701—52.45(422,85GA,SF452) cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes.

This rule is intended to implement Iowa Code section 422.35 and 2013 Iowa Acts, Senate File 452. [ARC 1303C, IAB 2/5/14, effective 3/12/14]

701—53.9(422) Gains and losses on property acquired before January 1, 1934. Where 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. *City National Bank of Clinton v. Iowa State Tax Commission*, 251 Iowa 603, 102 N.W.2d 381 (1960).

If as a result of this provision a basis is to be used for purposes of Iowa corporation 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 422.35.

701—53.10(422) Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit. Where provided for in the Internal Revenue Code, as detailed below, a deduction shall be allowed for the amount of credit to the extent that the credit increased federal taxable income.

53.10(1) For tax years beginning on or after January 1, 1977, the amount of credit allowable for federal work opportunity tax credit as provided for in Section 51 of the Internal Revenue Code shall be a deduction from Iowa taxable income to the extent the credit increased income.

53.10(2) For tax periods beginning on or after January 1, 1980, the amount of credit allowable for the federal alcohol and cellulosic biofuel fuels credit as provided for in Section 40 of the Internal Revenue Code shall be a deduction from Iowa taxable income to the extent the credit increased income.

This rule is intended to implement 2011 Iowa Code Supplement section 422.35 as amended by 2012 Iowa Acts, Senate File 2328.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

701—53.11(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, a taxpayer which is considered to be a small business corporation, as defined by subrule 53.11(2), is allowed a deduction for 50 percent of the first 12 months of wages paid or accrued during the tax years for work done in Iowa for employees first hired on or after January 1, 1984.

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 904.

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 chapter 913 applies.

For tax years beginning on or after January 1, 1989, a taxpayer which is considered to be a small business corporation, as defined by subrule 53.11(2) is allowed a deduction for 65 percent not to exceed \$20,000 of the first 12 months of wages paid or accrued during the tax year for work done in Iowa for employees first hired after January 1, 1989, who meet the above criteria.

53.11(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 Iowa division of job service of the department of employment services, 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.

53.11(2) The term “small business corporation” includes the operation of a farm but does not include the practice of a profession. The following conditions apply for the purpose of determining what constitutes a small business corporation.

a. A small business corporation shall not have had more than 20 full-time equivalent positions during each of the 26 consecutive weeks within the 52-week period immediately preceding the date on which the 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:

<u>Average Number of Weekly Hours</u>	<u>Category</u>
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. A small business corporation 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. A small business corporation 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.

53.11(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 intellectual disability, 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.

53.11(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.

53.11(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.

53.11(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 corporation 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.

53.11(7) For tax years ending after July 1, 1990, a taxpayer who did not qualify for the additional deduction for wages paid or accrued for work done in Iowa by certain individuals set forth above is allowed an additional deduction of 65 percent not to exceed \$20,000 of the first 12 months of wages paid or accrued for work done in Iowa for employees first hired on or after July 1, 1990, if the new employee is:

a. An individual domiciled in this state at the time of the 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 904, division IX.

b. 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 907A.1 applies.

The additional deduction is not 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 Iowa division of job service of the department of employment services, the additional deduction is 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.

The taxpayer must 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 whom the taxpayer claims the additional deduction for wages.

If the employee for whom an additional deduction for wages was allowed fails to successfully complete a probationary period and the taxpayer has already filed an Iowa corporation income tax return taking the additional deduction for wages, the taxpayer must file an amended return adding back the additional deduction for wages. The amended return must state the name and social security number of the employee who failed to successfully complete a probationary period.

53.11(8) 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. The conditions set out in the unnumbered paragraphs under paragraph "b" of subrule 53.11(7) also apply to the deduction for the hiring of certain individuals in this subrule.

This rule is intended to implement 2011 Iowa Code Supplement section 422.35 as amended by 2012 Iowa Acts, Senate File 2247.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

701—53.12(422) Federal income tax deduction. "Federal income taxes" shall mean those income taxes paid or payable to the United States Government and shall not include taxes paid or payable or taxes deemed to have been paid to a foreign country. *Construction Products, Inc. v. Briggs, State Board of Tax Review*, Case No. 25, February 1, 1972. "Federal income taxes" includes the federal alternative minimum tax. For tax years beginning on or after January 1, 1990, and before January 1, 1996, "federal income taxes" includes the federal environmental tax. Because the federal environmental tax is deducted in computing federal taxable income and Iowa Code subsection 422.35(4) only allows a deduction for 50 percent of the federal income tax paid or accrued, the federal environmental tax deducted in computing federal taxable income must be added to federal taxable income.

53.12(1) Cash basis taxpayer.

a. When a taxpayer is reporting on the cash basis, 50 percent of the amount of federal income taxes actually paid during the taxable period is allowable as a deduction, whether or not such taxes represent the preceding year's tax or additional taxes for prior years. Fifty percent of a federal tax refund shall be reported as income in the year received.

b. A corporation reporting on the cash basis may deduct 50 percent of the federal income tax on the accrual basis if an election is made upon filing the first return. If the corporation claims an accrual deduction on the first return, it shall be considered as an election. Once the election is made,

the corporation may change the basis of federal income tax deduction only with the permission of the director. If a change in accounting method is approved or required by the Internal Revenue Service, the director is deemed to have approved the change in the basis of the federal tax deduction.

c. The federal income tax deduction during the transitional period following a change in accounting method from cash to accrual is the accrual deduction in the year of change, plus any cash payment of federal income tax paid in the year of the change for the tax year prior to the change in accounting method, reduced by a refund of federal income tax paid for the tax year prior to the year of the change in accounting method received in the year of the change. For the year of change and years subsequent to the year of the change, the deduction shall be the accrual deduction plus any federal income tax paid for a tax year prior to the year of change as a result of an amended federal return or federal audit, reduced by any refund of federal income tax paid for a tax year prior to the year of the change in accounting method.

d. The federal income tax deduction during the transitional period following a change in accounting method from accrual to cash is the cash deduction in the year of change, plus any cash payment of federal estimated income tax paid in the year prior to the year of the change for the year of the change. Any refund of federal income tax from a tax year prior to the year of the change received in the year of the change or in a subsequent year is properly accrued to the prior tax year. Any payment of federal income tax due to an amended return or federal audit for a tax year prior to the year of the change made in the year of the change or a subsequent year is accrued to that prior tax year. (For information on amended returns, see 701—subrule 52.3(4).)

53.12(2) Accrual basis taxpayer.

a. The amount of federal income tax to be allowed as a deduction for an accrual basis taxpayer is limited to 50 percent of the actual federal income tax liability for that year.

b. Additional federal income taxes and refunds of federal income taxes (except for 53.12(2)“c”) shall be a part of the tax liability accrued for such prior years.

c. Refunds resulting from net operating loss carrybacks, investment credit carrybacks, unused excess profits tax credits, and similar items shall be included in income for Iowa corporation income tax purposes in the year in which such refunds are legally accrued.

53.12(3) Rescinded, effective February 2, 1977.

53.12(4) Consolidated federal income tax allocation.

a. When a corporation joins with at least one other corporation in the filing of a consolidated federal income tax return, the allowable deduction shall be 50 percent of the consolidated federal income tax liability allocable to that corporation. The allocation of the consolidated federal income tax shall be determined as follows: The net consolidated federal income tax liability is multiplied by a fraction, the numerator of which is the taxpayer’s federal taxable income as computed on a separate basis, and the denominator of which is the total federal taxable incomes of each corporation included in the consolidated return. If the computation of the taxable income of a member results in an excess of deductions over gross income such member’s taxable income shall be zero. *Sibley State Bank v. Bair, State Board of Tax Review*, Docket No. 182, May 26, 1978. *Internorth, Inc., and Northern Propane Gas Company v. Iowa State Board of Tax Review, Iowa Department of Revenue and Gerald D. Bair, Director of Revenue*, 333 N.W.2d 471 (Iowa 1983).

b. If a corporation joins with at least one other corporation in the filing of a consolidated federal income tax return, the federal income tax deduction allowed the Iowa taxpayer shall not exceed 50 percent of the consolidated federal income tax liability.

This rule is intended to implement Iowa Code section 422.35.

701—53.13(422) Iowa income taxes and Iowa tax refund. Iowa corporation income taxes paid or accrued during the tax year as may be applicable under the method of filing are permissible deductions for federal corporation income tax purposes, but are not permissible deductions for purposes of determining Iowa net taxable income. To the extent taxes were deducted in the determination of federal taxable income, they shall be added to federal taxable income for Iowa corporation income tax purposes. Refunds of Iowa income tax to the extent that the refunds were included in the determination of federal taxable

income shall be subtracted from federal taxable income, only to the extent that a deduction for Iowa income taxes was disallowed on a prior Iowa return. Iowa income tax refunds resulting from Iowa refundable tax credits are not allowed as a deduction for Iowa corporation income tax purposes.

EXAMPLE: Corporation A reports income on a cash basis and made Iowa estimated payments of \$2,000 during the 2003 tax year. The \$2,000 of estimated payments was claimed as a deduction for federal income tax purposes, but was not allowed as a deduction for Iowa tax purposes. The 2003 Iowa return reported a tax liability of \$1,600. Corporation A had \$2,000 of Iowa estimated payments and a \$500 ethanol blended gasoline tax credit, and received a \$900 Iowa tax refund in 2004. Of the \$900 refund reported as income on the federal return, Corporation A will be allowed a \$400 (\$2,000 - \$1,600) reduction on the Iowa return for 2004.

This rule is intended to implement Iowa Code section 422.35.

701—53.14(422) Method of accounting, accounting period. The return shall be computed on the same basis and for the same accounting period as the taxpayer's return for federal corporation income tax purposes. Permission to change accounting methods or accounting periods for corporation tax purposes is not required provided the taxpayer furnishes the department with a copy of the federal consent.

This rule is intended to implement Iowa Code section 422.35.

701—53.15(422) Consolidated returns.

53.15(1) Definition. The term "common parent" as used in these rules shall have the same general meaning as when used in the federal income tax regulation. However, where the common parent is not subject to the Iowa income tax because of the provisions of 701—subrule 52.1(1) or because of specific exemption under Iowa Code section 422.34, the common parent shall designate as the agent for the affiliated group, one of its subsidiaries subject to the Iowa income tax and shall notify the director of the same in writing. Where the common parent has designated one of its subsidiaries to act as agent for the affiliated group, reference in this rule to "common parent" shall mean the designated agent.

Unless otherwise distinctly expressed, the terms used in this rule shall have the same meaning as when used in a comparable context in the federal income tax regulations for consolidated returns except for determining whether an affiliated group had exercised its privilege of filing a consolidated return. All references to the "commissioner" or "district director" in the federal regulations shall be construed to mean the director for purposes of the Iowa rules.

a. An affiliated group of corporations which did not file a consolidated return for the immediately preceding taxable year may file a consolidated return in lieu of separate returns for the taxable year. Each corporation which is subject to the Iowa corporation income tax and has been a member during any part of the taxable year for which the consolidated return is to be filed must consent (as provided in paragraph 53.15(1) "d") to the filing of the consolidated return.

b. If a group wishes to exercise its privilege of filing a consolidated return, the consolidated return must be filed not later than the date prescribed by Iowa Code section 422.21 (including extensions of time) for the filing of the common parent's return. The consolidated return may not be withdrawn after the last day for filing (including extensions of time) but the group may change the basis of its return at any time prior to the last day.

c. The consolidated return shall be made on Form IA-1120 for the group by the common parent corporation. The common parent corporation of the group must attach a copy of the federal Form 851 (Affiliations Schedule) to the consolidated return.

d. If a group wishes to exercise its privilege of filing a consolidated return, each subsidiary must consent to the filing of the consolidated return for the year. The subsidiaries must consent to the filing of an Iowa consolidated return by joining in the filing of an Iowa consolidated return on or before the due date (including any extensions of time). If both separate and consolidated returns are filed on or before the due date (including any extensions of time), the latest returns filed will be considered as the taxpayers' election in regards to the filing of separate or consolidated returns.

e. The common parent, for all purposes other than the making of the consent required by subrule 53.15(1) "a," shall be the sole agent for each subsidiary in the group, duly authorized to act in its own

name in all matters relating to the tax liability for the consolidated return year. No subsidiary shall have authority to act for or to represent itself in any matter. The provisions of this paragraph shall apply whether or not a consolidated return is made for any subsequent year and whether or not one or more subsidiaries have become or have ceased to be members of the group at any time. If a subsidiary has ceased to be a member of the group and if the subsidiary files written notice of the cessation with the director, then upon request of the subsidiary, the director will furnish it with a copy of any notice of deficiency in respect of the tax for a consolidated return year for which it was a member. The filing of the written notification and request by a corporation shall not have the effect of limiting the scope of the agency of the common parent.

f. Unless the director agrees to the contrary, an agreement entered into by the common parent extending the time within which a notice of deficiency may be issued, or a levy or a proceeding in court begun in respect of the tax for a consolidated return year shall be applicable to each corporation which was a member of the group during any part of the taxable year and to each corporation, the income of which was included in the consolidated return for the taxable year, notwithstanding that the liability of the corporation is subsequently computed on the basis of a separate return under these rules.

g. If the common parent corporation contemplates dissolution, or is about to be dissolved, or if for any other reason its existence is about to terminate, it shall forthwith notify the director of that fact and designate another member to act as its agent in its place to the same extent and subject to the same conditions and limitations as are applicable to the common parent. If this notice is not given by the common parent, the remaining members may, subject to the approval of the director, designate another member to act as agent, and notice of the designation shall be given to the director. Until a notice in writing designating a new agent has been approved by the director, any notice of deficiency or other communications mailed to the common parent shall be considered as having been properly mailed to the agent of the group. If the director has reasons to believe that the existence of the common parent has terminated, the director may, if deemed advisable, deal directly with any member in respect of its liability.

53.15(2) *When director may require consolidated return.* In accordance with the provisions of rule 701—53.15(422), the director may require a consolidated return for those members of an affiliated group of corporations which would be eligible to elect to consolidate their incomes under Iowa Code section 422.37 if the filing of separate returns for such corporations would improperly reflect the taxable incomes of said corporations or of said group.

53.15(3) *Discontinuance of filing consolidated returns.*

a. An affiliated group which filed (or was required to file) a consolidated return for the immediately preceding taxable year is required to file a consolidated return for the taxable year unless it is allowed to discontinue filing consolidated returns, or unless a federal consolidated return is not filed by the group.

b. In the event that a consolidated filing for Iowa tax purposes is discontinued for any reason, the common parent shall so notify the department by letter. The mere filing of separate returns does not, in itself, constitute sufficient notice.

c. The following constitute factors for determining when consolidated filing for Iowa tax purposes can be discontinued:

(1) If the filing of separate returns will more clearly disclose the taxable income of each member of the affiliated group. Corporations should note that such determination is vested in the director. Therefore, corporations should make application to the director within a reasonable time prior to the due date of the return (including extensions of time). Normally, this would be not later than 90 days prior to said due date. The application should set forth in detail the taxable income on both a consolidated and separate basis together with the reasons why separate returns would more clearly disclose Iowa taxable income. The mere fact that the consolidated tax liability is greater or less than the combined separate liabilities is not, of itself, a ground for discontinuance of consolidated filing.

(2) If one or more of the members of the affiliated group cease to be subject to Iowa corporate income tax, consolidation may be discontinued in whole or in part.

(3) If one or more of the members of the affiliated group change in character so that they are no longer taxable under the Iowa corporate income tax law.

EXAMPLE: Common parent A is a manufacturer. Subsidiary B is a company engaged in small loans. A and B file consolidated Iowa returns. In a subsequent taxable year, B changes its business by surrendering its small loan company license and obtains a state bank charter. Even though A and B continue to file federal consolidated returns, B is now a corporation exempt from tax under Iowa Code section 422.34. Therefore A and B should discontinue filing Iowa consolidated returns.

(4) If the affiliated group is purchased by another corporation or affiliated group so that after the purchase the stockholders own less than 50 percent of the fair market value of all classes of outstanding stock of the new corporation or affiliated group then the old group must discontinue filing Iowa consolidated returns. The new group may exercise its privilege of filing a consolidated return.

d. If a group is allowed to discontinue filing consolidated returns for any taxable year, then each member of the affiliated group subject to Iowa tax must file a separate return for such year on or before the last day prescribed by law (including extensions of time) for the filing of the consolidated return for such year.

e. A group shall be considered as remaining in existence, for the purposes of the Code, in accordance with the rules prescribed in Treasury Regulation Section 1.1502-75(d).

f. If a consolidated return erroneously includes the income of one or more corporations which were not members of the group at any time during the consolidated return year, the tax liability of such corporations will be determined upon the basis of separate returns (or a consolidated return of another group, if paragraph 53.15(1)“c” or 53.15(3)“a” applies) and the consolidated return will be considered as including only the income of the corporations which were members of the group during that taxable year.

g. In any case in which amounts have been assessed and paid upon the basis of a consolidated return, and where the tax liability of one or more of the corporations included in the consolidated return is to be computed in the manner described in paragraph 53.15(3)“f,” the amounts so paid shall be allocated between the group composed of the corporations properly included in the consolidated return and each of the corporations, whose tax liability is to be computed on a separate basis (or on the basis of a consolidated return of another group) in such manner as the corporations which were included in the consolidated return, and where the tax liability of one or more of the corporations included absence of an agreement, the tax liability of the group shall be allocated under subrule 53.12(4).

h. The taxable year of members of the group, including rules for changing the parent’s taxable year, income to be included in the separate returns, and the time for making separate returns for periods not included in a consolidated return for the purposes of the Iowa Code, shall be in accordance with the rules prescribed in Treasury Regulation Section 1.1502-76(a)-(c).

53.15(4) Determination of consolidated Iowa income.

a. Unless otherwise provided by these rules or manifestly inconsistent with the provisions of the Iowa Code, the consolidated taxable income for a consolidated return year under the Iowa Code shall be determined in the same manner and under the same procedures, including intercompany adjustments and eliminations, as are required by the federal income tax regulations in the case of a federal consolidated return.

b. If the Iowa affiliated group differs in its members from the federal affiliated group, such nonqualifying member(s) shall not be considered includable corporations and all computations hereunder shall be made as if such member(s) were not members of the affiliated group. The consolidated federal income tax liability shall be allocated between includable corporations and nonincludable corporations by subrule 53.12(4).

c. The apportionment provisions of Iowa Code section 422.33 shall be taken into account by an affiliated group doing business within and without Iowa. All members of an affiliated group which join in the filing of an Iowa consolidated return shall determine the portion of the consolidated net income earned within and without Iowa by the same method. All intercompany transactions shall be eliminated in the determination of the apportionment factors.

The gross receipts of each corporation which joins in the filing of an Iowa consolidated corporation income tax return shall be included in the computation of the business activity ratio. The gross receipts of each corporation shall be included in the numerator of the business activity ratio to the extent that it has

nexus in Iowa and its gross receipts are not eliminated by intercompany adjustments and are considered Iowa gross receipts by rules 701—54.2(422) to 701—54.8(422). The gross receipts of each corporation shall be included in the denominator of the business activity ratio to the extent its gross receipts are not eliminated by intercompany adjustments.

d. On or after January 1, 2016, see 701—Chapter 242 for requirements of an out-of-state business to be a part of an affiliated group filing an Iowa consolidated return that enters Iowa to perform disaster and emergency-related work during a disaster response period as those terms are defined in Iowa Code section 29C.24.

53.15(5) Schedules. Supporting schedules shall be filed with the consolidated return. The statement of gross income and deductions and other schedules required for each corporation shall be prepared and filed in columnar form so that the details of the items of gross income, deductions, and credits for each member may be readily ascertained. A column shall also be provided giving effect to any eliminations and adjustments. The items included in the column for eliminations and adjustments should be symbolized to identify contra items affected, and suitable explanations appended, if necessary. Similar schedules shall contain in columnar form a reconciliation of retained earnings for each corporation, together with a reconciliation of consolidated retained earnings. Consolidated balance sheets at the beginning and close of the taxable year of the group shall accompany the consolidated return prepared in a form similar to that required for other schedules. Transactions with a subsidiary which is not included as part of the Iowa consolidated return shall not be considered as intercompany transactions for elimination purposes in computing the consolidated Iowa taxable income for the return period.

53.15(6) Liability for tax.

a. Except as provided in paragraph 53.15(6)“*b*,” the common parent corporation and each subsidiary subject to the Iowa corporation income tax which was a member of the affiliated group during any part of the consolidated return year shall be severally liable for the tax for the year computed in accordance with Iowa Code chapter 422, on or before the due date (not including extensions of time) for the filing of the consolidated return for that year.

b. If a subsidiary has ceased to be a member of the group and if the cessation resulted from a bona fide sale or exchange of its stock for fair value and occurred prior to the date upon which any deficiency is assessed, the director may make an assessment and collection of the deficiency from the former subsidiary in an amount not exceeding the portion of the deficiency which the director may determine to be allocable to it. If the director makes assessment and collection of any part of a deficiency from the former subsidiary, then for purposes of any credit or refund of the amount collected from the former subsidiary the agency of the common parent under the provisions of paragraph 53.15(1)“*e*” shall not apply.

c. No agreement entered into by one or more members of the affiliated group with any other member of the group shall in any case have the effect of reducing the liability prescribed under this subrule.

53.15(7) Computation of contribution. Computation of a separate corporation’s contribution to consolidated income or net operating loss subject to Iowa tax for purposes of net operating loss carryover and carryback limitations shall be as follows:

$$\frac{A}{B} \times C \times \frac{D}{A} + E = \begin{array}{l} \text{separate corporation contribution to} \\ \text{consolidated income subject to Iowa tax.} \end{array}$$

A = Separate corporation gross sales within and without Iowa after elimination of all intercompany transactions.

B = Consolidated gross sales within and without Iowa after elimination of all intercompany transactions.

C = Iowa consolidated net income subject to apportionment.

D = Separate corporation gross sales within Iowa after elimination of all intercompany transactions.

E = Separate corporation income allocable to Iowa.

53.15(8) Limitations on net operating loss carryover and carryback.

a. Definitions.

(1) The term “separate return year” means a year in which a corporation filed a separate return and also a year for which it joined (or was required to join) in the filing of an Iowa consolidated return by another affiliated group.

(2) The term “separate return limitation year” means any separate return year of a member of the group or of a predecessor of the member.

b. Limitation on net operating loss carryover. A net operating loss from a separate return limitation year of a member of the group may be carried over only to the extent that the member contributed to the Iowa consolidated taxable income as computed under subrule 53.15(7). A net operating loss carryover from a separate return limitation year cannot create or increase a consolidated net operating loss which is carried back for tax years beginning prior to January 1, 2009.

A consolidated net operating loss may be carried over to a consolidated return year without limitation even though in the carryover year the affiliated group contains members which were not members of the group in the loss year.

If a member of the affiliated group in the loss year leaves the group through the sale of its stock or because it is now a corporation exempt from tax under Iowa Code section 422.34, its share, as determined by subrule 53.15(7), of the unabsorbed consolidated net operating loss at the end of the consolidated return year during which the member left the group or became exempt from tax may not be carried forward to a subsequent consolidated return.

c. Limitation on net operating loss carryback for tax periods beginning prior to January 1, 2009. A member’s share of an Iowa consolidated net operating loss as computed under subrule 53.15(7) must be carried back to a separate return year, unless the affiliated group elected to carry the net operating loss forward. However, if the member was not in existence in the carryback year but had been a member of the group for every tax year of its existence, its share of the Iowa consolidated loss may be carried back to a separate return year of the common parent.

If a consolidated net operating loss is carried back to a consolidated return year and all members of the affiliated group are the same in the carryback year as in the loss year, the consolidated net operating loss may be carried back without limitation. If there are members of the affiliated group in the loss year which were not members in the carryback year, then the formula in subrule 53.15(7) must be used to determine the portion of the consolidated net operating loss attributable to the members in existence in the carryback year and which may be carried back. Any member of the affiliated group which was a member of the loss-year affiliated group which has been a member of the group since its formation will be regarded as having been a member of the group in the carryback year even though it was not then in existence. A merger or liquidation of members within the affiliated group will be disregarded in determining whether there has been a change in the group between the loss year and the carryback year.

The amount of net operating loss that may be carried back from a separate return year to a consolidated return year is limited to the extent that the former member contributed to the Iowa consolidated taxable income as computed under subrule 53.15(7).

This rule is intended to implement Iowa Code section 422.35 as amended by 2009 Iowa Acts, Senate File 483, and section 422.37.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 9103B, IAB 9/22/10, effective 10/27/10; ARC 3085C, IAB 5/24/17, effective 6/28/17]

701—53.16(422) Federal rulings and regulations. In determining whether “taxable income,” “net operating loss deduction” or any other deductions are computed for federal tax purposes under, or have the same meaning as provided by, the Internal Revenue Code, the department will use applicable rulings and regulations that have been duly promulgated by the Commissioner of Internal Revenue, unless the director has created rules and regulations or has exercised discretionary powers as prescribed by statute which call for an alternative method for determining “taxable income,” “net operating loss deduction,” or any other deductions, or unless the department finds that an applicable Internal Revenue ruling or regulation is unauthorized according to the Iowa Code.

This rule is intended to implement Iowa Code section 422.35.

701—53.17(422) Depreciation of speculative shell buildings.

53.17(1) For tax years beginning on or after July 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 taxable income in order to deduct depreciation under this rule.

53.17(2) On sale or other disposition of the speculative shell building, the taxpayer must report on the taxpayer's Iowa corporation income tax return the same gain or loss reported on the taxpayer's federal corporation 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.

53.17(3) For the purposes of this rule, the term "speculative shell building" means a building as defined in Iowa Code section 427.1, subsection (27) "c."

This rule is intended to implement Iowa Code section 422.35.

701—53.18(422) Deduction of multipurpose vehicle registration fee. For tax years beginning on or after January 1, 1992, and before January 1, 2005, corporations may claim a deduction for 60 percent of the amount of the registration fee paid for a multipurpose vehicle under Iowa Code section 321.124, subsection 3, paragraph "h." In order to qualify for this deduction, no part of the multipurpose vehicle registration fee may have been deducted as an ordinary and necessary business expense.

For tax years beginning on or after January 1, 2005, the deduction for Iowa corporation income tax for multipurpose vehicle registration fees is the same as allowed under Section 164 of the Internal Revenue Code for federal tax purposes.

This rule is intended to implement Iowa Code section 422.35.

701—53.19(422) Deduction of foreign dividends. For tax years beginning on or after January 1, 1992, corporations may claim a deduction based on percentage of ownership as set forth in Section 243 of the Internal Revenue Code for foreign dividends including Subpart F income as defined in Section 952 of the Internal Revenue Code. See *Kraft General Foods, Inc. v. Iowa Department of Revenue and Finance*, 505 U.S. 71, 120 L.Ed 59, 112 S.Ct. 2365 (1992).

This rule is intended to implement Iowa Code section 422.35.

701—53.20(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. No social security tax credit is allowed on the Iowa corporation income tax return.

This rule is intended to implement Iowa Code section 422.35 as amended by 1995 Iowa Acts, chapter 152.

701—53.21(422) Deductions related to the Iowa educational savings plan trust. For tax years beginning on or after January 1, 2016, certain qualifying organizations may establish Iowa education savings plan trust accounts as participants, as described in Iowa Code chapter 12D. Taxpayers may make contributions to such qualifying organizations so that the organization can deposit the contribution into the organization's Iowa education savings plan trust account. However, for Iowa income tax purposes, a taxpayer must add back any portion of the federal charitable contribution deduction allowed

for a contribution to a qualifying organization, to the extent that the taxpayer designated that any part of such contribution be used for the direct benefit of a dependent of a shareholder or for the benefit of any other specific person chosen by the taxpayer.

This rule is intended to implement Iowa Code section 422.35 as amended by 2016 Iowa Acts, chapter 1107.

[ARC 3664C, IAB 2/28/18, effective 4/4/18]

701—53.22(422) Additional first-year depreciation allowance.

53.22(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 corporation 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.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: Taxpayer acquired a \$100,000 qualifying asset on January 1, 2002, which has a five-year life for depreciation purposes. Using the bonus depreciation provision in Section 168(k) of the Internal Revenue Code, taxpayer was entitled to a \$44,000 depreciation deduction on the federal return for 2002. For Iowa purposes, taxpayer must use the MACRS depreciation method which results in a \$20,000 depreciation deduction on the Iowa return for 2002. Therefore, a \$24,000 (\$44,000 – \$20,000) increase to net income relating to this depreciation adjustment must be made on the Iowa return for 2002.

EXAMPLE 2: Taxpayer acquired a \$1,000,000 qualifying asset on January 1, 2002, which has a ten-year life for depreciation purposes. This asset was sold on December 31, 2005, for \$500,000. Using the bonus depreciation provision, taxpayer claimed \$677,440 of depreciation deductions on the federal returns for 2002-2005. This results in a basis for this asset of \$322,560 (\$1,000,000 – \$677,440), and a gain of \$177,440 (\$500,000 – \$322,560) on the federal return for 2005 on the sale of the asset.

Using the MACRS depreciation method, taxpayer claimed \$539,200 of depreciation deductions on the Iowa returns for 2002-2005. This results in a basis for this asset of \$460,800 (\$1,000,000 – \$539,200), and a gain of \$39,200 (\$500,000 – \$460,800) on the Iowa return for 2005 on the sale of the asset. Therefore, a decrease to net income of \$138,240 (\$177,440 – \$39,200) relating to this gain adjustment must be made on the Iowa return for 2005.

53.22(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 corporation income tax. If the taxpayer elects to take the 50 percent bonus depreciation, the depreciation deduction allowed on the Iowa corporation 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.

See 701—subrule 40.60(2), paragraph “a,” for examples illustrating how this subrule is applied.

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.

53.22(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 corporation 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.

The following nonexclusive examples illustrate how this subrule applies:

EXAMPLE 1: Taxpayer acquired a \$100,000 qualifying asset on January 10, 2008, which has a five-year life for depreciation purposes. Using the bonus depreciation provision in Section 168(k) of the Internal Revenue Code, taxpayer was entitled to a \$44,000 depreciation deduction on the federal return for 2008. For Iowa purposes, taxpayer must use the MACRS depreciation method which results in a \$20,000 depreciation deduction on the Iowa return for 2008. Therefore, a \$24,000 (\$44,000 – \$20,000) increase to net income relating to this depreciation adjustment must be made on the Iowa return for 2008.

EXAMPLE 2: Taxpayer acquired a \$1,000,000 qualifying asset on January 10, 2008, which has a ten-year life for depreciation purposes. This asset was sold on December 31, 2011, for \$500,000. Using the bonus depreciation provision, taxpayer claimed \$677,440 of depreciation deductions on the federal returns for 2008-2011. This results in a basis for this asset of \$322,560 (\$1,000,000 – \$677,440), and a gain of \$177,440 (\$500,000 – \$322,560) on the federal return for 2011 on the sale of the asset.

Using the MACRS depreciation method, taxpayer claimed \$539,200 of depreciation deductions on the Iowa returns for 2008-2011. This results in a basis for this asset of \$460,800 (\$1,000,000 – \$539,200), and a gain of \$39,200 (\$500,000 – \$460,800) on the Iowa return for 2011 on the sale of the asset. Therefore, a decrease to net income of \$138,240 (\$177,440 – \$39,200) relating to this gain adjustment must be made on the Iowa return for 2011.

53.22(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 corporation 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.

53.22(5) *Assets acquired after December 31, 2009, but before January 1, 2014.* For tax periods beginning after December 31, 2009, but beginning before January 1, 2014, the bonus depreciation authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 111-240, Section 2022, Public Law No. 111-312, Section 401, and Public Law No. 112-240, Section 331, does not apply for Iowa corporation 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, 2014, 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, 2014, can be calculated on Form IA 4562A.

See subrule 53.22(3) for examples illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.35 as amended by 2013 Iowa Acts, Senate File 106.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13]

701—53.23(422) Section 179 expensing.

53.23(1) *In general.* Iowa taxpayers that elect to expense certain depreciable business assets in the year the assets were placed in service under section 179 of the Internal Revenue Code must also expense those same assets for Iowa income tax purposes in that year. However, for certain years, the Iowa limitations on this deduction are different from the federal limitations for the same year. This means that for some tax years, adjustments are required to determine the correct Iowa section 179 expensing deduction, as described in this rule.

53.23(2) *Claiming the deduction.*

a. Timing and requirement to follow federal election. A taxpayer that takes a federal section 179 deduction must also take the deduction for the same asset in the same year for Iowa purposes, except as expressly provided by Iowa law or this rule. A taxpayer that takes a federal section 179 deduction is not permitted to opt out of taking the same deduction for Iowa purposes. A taxpayer that does not take a federal section 179 deduction on a specific qualifying asset is not permitted to take a section 179 deduction for Iowa purposes on that asset.

b. Qualifying for the deduction. Whether a specific business asset qualifies for a section 179 deduction is determined by the Internal Revenue Code (Title 26, U.S. Code) and applicable federal regulations for both federal and Iowa purposes.

c. Amount of the Iowa deduction. Generally, the Iowa deduction must equal the amount of the federal deduction taken for the same asset in the same year, subject to special Iowa limitations. The following chart provides a comparison of the Iowa and federal section 179 dollar limitations and reduction limitations. See rule 701—40.65(422) for the section 179 rules applicable to individuals

and other noncorporate entities, and see rule 701—59.24(422) for the section 179 rules applicable to financial institutions subject to the franchise tax.

Section 179 Deduction Allowances Under Federal and Iowa Law				
	Federal		Iowa	
Tax Year	Dollar Limitation	Reduction Limitation	Dollar Limitation	Reduction Limitation
2003	\$ 100,000	\$ 400,000	\$ 100,000	\$ 400,000
2004	102,000	410,000	102,000	410,000
2005	105,000	420,000	105,000	420,000
2006	108,000	430,000	108,000	430,000
2007	125,000	500,000	125,000	500,000
2008	250,000	800,000	250,000	800,000
2009	250,000	800,000	133,000	530,000
2010	500,000	2,000,000	500,000	2,000,000
2011	500,000	2,000,000	500,000	2,000,000
2012	500,000	2,000,000	500,000	2,000,000
2013	500,000	2,000,000	500,000	2,000,000
2014	500,000	2,000,000	500,000	2,000,000
2015	500,000	2,000,000	500,000	2,000,000
2016	500,000	2,010,000	25,000	200,000
2017	510,000	2,030,000	25,000	200,000
2018	1,000,000	2,500,000	70,000	280,000
2019	1,020,000	2,550,000	100,000	400,000
2020 and later	Iowa limitations are the same as federal			

d. Reduction. Both the federal and the Iowa deductions for section 179 assets are reduced (phased out dollar for dollar) for taxpayers whose total section 179 assets placed in service during a given year cost more than the amount specified (reduction limitation) for that year. Like the deduction limitation, the Iowa and federal reduction limitations are different for certain years. See paragraph 53.23(2) “c” for applicable limitations.

EXAMPLE: Taxpayer, a corporation, purchases \$400,000 worth of qualifying section 179 assets and places all of them in service in 2018. Taxpayer claims a section 179 deduction of \$400,000 for the full cost of the assets on the 2018 federal return. For corporations, the Iowa section 179 deduction for 2018 is phased out dollar for dollar by the amount of section 179 assets placed in service in excess of \$280,000. This means that, for 2018, the Iowa deduction is fully phased out if the taxpayer placed in service section 179 assets that cost, in total, more than \$350,000. Since the cost of the qualifying assets in this example exceeds the Iowa section 179 phase-out limit, the taxpayer cannot claim any section 179 deduction on the Iowa return. However, the taxpayer may depreciate the entire cost of the assets for Iowa purposes.

e. Amounts in excess of the Iowa limits.

(1) Recovering the excess. Due to the differences between the Iowa and federal limitations for certain years, taxpayers may have a federal section 179 deduction that exceeds the amount allowed for Iowa purposes. This excess amount is handled in different ways depending on the source of the deduction.

1. Assets placed in service by the taxpayer or entity reporting the deduction. The cost of any section 179 assets placed in service by the taxpayer in excess of the Iowa limitation for a given year may be recovered through regular depreciation under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). The Iowa section 179 and depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa and federal law are calculated and tracked on forms made available on the department’s website.

EXAMPLE: Taxpayer, a corporation, purchases a \$100,000 piece of equipment and places it in service in 2018. Taxpayer claims a section 179 deduction of \$100,000 for the full cost of the equipment on the 2018 federal return. Taxpayer is also required to claim a section 179 deduction of \$70,000 on the 2018 Iowa return (the full amount of the federal deduction up to the Iowa limit for corporations for 2018). The taxpayer can depreciate the remaining \$30,000 cost of the equipment for Iowa purposes.

2. Special election for assets placed in service by a pass-through entity when the section 179 deduction is claimed by an owner of that pass-through. See subrule 53.23(3) for information on a special election available to certain owners of pass-through entities related to any section 179 deductions passed through from a partnership or other entity that, in the aggregate, exceed the Iowa limitations.

(2) Special information for pass-throughs. In the case of pass-through entities, section 179 limitations apply at both the entity level and the owner level. Pass-through entities that are required to file an Iowa return and that actually place section 179 assets in service should follow 53.23(2)“e”(1)“1” to account for any assets for which the total federal section 179 deductions for a given year exceeded the Iowa limitation. Owners of pass-throughs receiving section 179 deductions from one or more pass-throughs that, in the aggregate, exceed the Iowa limitations should follow 53.23(2)“e”(1)“2.”

EXAMPLE: A, Inc. (a corporation doing business exclusively in Iowa) owns 50 percent interests in each of three partnerships: C, D, and E. Partnership C, which also does business exclusively in Iowa, places \$200,000 worth of section 179 assets in service during tax year 2019 and claims a federal section 179 deduction for the full cost of the assets. Because C is required to file an Iowa partnership return, C is subject to the Iowa section 179 limitations for 2019 and must adjust its Iowa section 179 deduction as provided in 701—numbered paragraph 40.65(2)“e”(1)“1.” C passes through 50 percent of its section 179 deduction (\$100,000 for federal purposes, \$50,000 for Iowa purposes) to A, Inc. A, Inc. also receives \$50,000 each in section 179 deductions from D and E, for a total of \$150,000 in section 179 deductions (for Iowa purposes) in 2019. A, Inc. is subject to the \$100,000 Iowa section 179 deduction limitation for 2019, but because A, Inc. received total section 179 deductions from one or more pass-throughs in excess of the 2019 Iowa limitation, A, Inc. is eligible for the special election referenced in 53.23(2)“e”(1)“2.”

f. Income limitation. The Iowa section 179 deduction for any given year is limited to the taxpayer’s income from active conduct in a trade or business in the same manner that the section 179 deduction is limited for federal purposes. If an allowable Iowa section 179 deduction exceeds the taxpayer’s business income for a given year, any excess allowable Iowa section 179 deduction may be carried forward as described in paragraph 53.23(2)“g.”

g. Carryforward. This paragraph applies only to amounts that do not exceed the Iowa section 179 deduction limitations for a given year but do exceed the taxpayer’s business income for that year. As with the federal deduction, allowable Iowa section 179 deductions claimed in a given year that exceed a taxpayer’s business income may be carried forward and claimed in future years. This carryforward, if any, is calculated using only amounts up to the Iowa limit. Any federal section 179 deduction the taxpayer claimed in excess of the Iowa limit is not an Iowa section 179 deduction and therefore is not eligible for the carryforward described in this paragraph. Such amounts must instead be recovered as described in paragraph 53.23(2)“e,” or in subrule 53.23(3) for taxpayers receiving the deduction from one or more pass-through entities and making the special election as described in that subrule.

h. Difference in basis. Iowa adjustments for differences between the Iowa and federal section 179 deduction limitations may cause the taxpayer to have a different basis in the same asset for Iowa and federal purposes. Taxpayers are required to use forms made available on the department’s website to calculate and track these differences.

53.23(3) Section 179 deduction received from a pass-through entity. In some cases, an entity that receives income from one or more pass-through entities may receive a section 179 deduction in excess of the Iowa deduction limitation listed in paragraph 53.23(2)“c” for a given year. The entity may be eligible for a special election with regard to that excess section 179 deduction, as described in this subrule.

a. Tax years beginning before January 1, 2018. For tax years beginning before January 1, 2018, the amount of any section 179 deduction received by a corporation (both C and S corporations) or an entity subject to the corporate income tax in excess of the Iowa deduction limitation for that year is not eligible for the special election.

b. Special election available for tax years 2018 and 2019. For tax years beginning on or after January 1, 2018, but before January 1, 2020, a corporation (both C and S corporations) or an entity subject to the corporate income tax that receives a section 179 deduction from one or more pass-through entities in excess of the Iowa deduction limitation for that tax year may elect to deduct the excess in future years, as described in this subrule. See rule 701—40.65(422) for rules applicable to individuals and other noncorporate entities, and see rule 701—59.24(422) for rules applicable to financial institutions subject to the franchise tax.

(1) This special election applies only to section 179 deductions passed through to the corporation or entity subject to the corporate income tax by one or more other entities.

(2) If the total Iowa section 179 deduction passed through to the corporation or entity subject to the corporate income tax exceeds the federal section 179 deduction limitation for that year, the corporation or other entity may only use the amount up to the federal limitation when calculating the deduction under this election. Any amount in excess of the federal limitation shall not be deducted for Iowa purposes.

c. Section 179 assets of a corporation or entity subject to the corporate income tax. A corporation or entity subject to the corporate income tax that makes this special election may not claim an Iowa section 179 deduction for any assets the corporation or entity placed in service during the same year but must instead depreciate such assets using the modified accelerated cost recovery system (MACRS) without regard to bonus depreciation under Section 168(k) of the Internal Revenue Code. To the extent the corporation or entity claimed a federal section 179 deduction on those assets, the Iowa depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa law and federal law are calculated and tracked on forms made available on the department's website.

EXAMPLE: A, Inc., a corporation doing business in Iowa, places in service \$20,000 worth of section 179 assets in tax year 2019 and claims the deduction for the full amount for federal purposes. A, Inc. is also a member of B, LLC, an entity that has elected to be taxed as a partnership for federal purposes and does not do any business in Iowa. B, LLC also places section 179 assets in service, properly claims a federal section 179 deduction, and passes a total of \$150,000 of that deduction through to A, Inc. For federal purposes, A, Inc. has a total of \$170,000 in section 179 deductions. Because A, Inc. has section 179 deductions from a pass-through that exceed the Iowa limitation for 2019, A, Inc. is eligible for the special election. A, Inc. makes the special election and claims the maximum Iowa section 179 deduction of \$100,000 on the amount passed through from B, LLC. Under the special election, A, Inc. will be allowed to deduct the remaining \$50,000 passed through from B, LLC over the next five years, as described in paragraph 53.23(3)"e." However, because A, Inc. made the special election, A, Inc. will be required to depreciate the entire \$20,000 cost of the assets A, Inc. placed in service in 2019.

d. Calculating the special election. A corporation or other entity subject to the corporate income tax that elects to take advantage of the special election must first add together all section 179 deductions which the corporation or other entity received from all relevant pass-through entities. The corporation or other entity must claim an aggregate Iowa section 179 deduction equal to the Iowa limit for the tax year. This amount must be subtracted from the total. Whatever remains is the amount the corporation or other entity will be permitted to deduct (special election deduction) in future years.

e. Special election deduction.

(1) Calculation. The remaining amount from paragraph 53.23(3)"d" must be separated into five equal shares.

(2) Claiming the special election deduction. The corporation or other entity may deduct one of the five shares in each of the next five years. The dollar limitations and reduction limitations on section 179 deductions do not apply to special deduction amounts allowed over the five-year period under this paragraph.

(3) Excess special deduction. The special election deduction for a given year is limited to the taxpayer's business income for that year. Any excess may be carried forward to future years. Any amounts carried forward under this subparagraph shall be added to, and treated in the same manner as, regular Iowa section 179 deduction carryforwards as described in paragraph 53.23(2)"g."

EXAMPLE: D, Inc., a corporation doing business in Iowa, is a partner in a partnership that does not do business in Iowa. In 2019, the partnership passes through a \$600,000 federal section 179 deduction and

does not recalculate the deduction for Iowa purposes because the partnership has no obligation to file an Iowa return. D, Inc. claims an Iowa section 179 deduction of \$100,000 (the 2019 Iowa limitation) and elects the five-year carryforward for the rest, meaning the corporation will be allowed to take a \$100,000 Iowa deduction in each of the next five years.

In 2020, D, Inc. is eligible for the \$100,000 deduction carried forward under the election, but the corporation only has \$50,000 in business income. The deduction is limited to business income, so the corporation can only use \$50,000 of the deduction in this year. However, D, Inc. will be permitted to treat the excess \$50,000 as a section 179 carryforward and use it to offset business income in future years until the deduction is used up.

f. Basis. The individual's or entity's basis in the pass-through entity assets is adjusted by the full amount of the section 179 deduction passed through in the year that the section 179 deduction is received and is therefore the same for both Iowa and federal purposes.

g. Later tax years. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal section 179 deduction and special Iowa treatment for excess section 179 deductions received from pass-throughs is not available.

This rule is intended to implement Iowa Code section 422.35 as amended by 2019 Iowa Acts, Senate File 220.

[ARC 9103B, IAB 9/22/10, effective 10/27/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13; ARC 4142C, IAB 11/21/18, effective 12/26/18; ARC 4517C, IAB 6/19/19, effective 7/24/19]

701—53.24(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 corporation 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 purposes 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.

53.24(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 corporation 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 53.24(2), information must be provided in the statement on that portion of the gain that qualified for the involuntary conversion.

53.24(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 corporation 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 corporation 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 corporation 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 corporation 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 corporation income tax return relating to the gain that resulted from the involuntary conversion.

This rule is intended to implement Iowa Code section 422.35.

701—53.25(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.

53.25(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 that is an Iowa-based business may exclude, to the extent included in federal taxable 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—52.34(15,422). An Iowa-based business is a business whose commercial domicile as defined in Iowa Code section 422.32(3) is in Iowa.

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—52.34(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 corporation which is domiciled in Iowa. If this same corporation receives income that is a qualified expenditure for purposes of the film qualified expenditure tax credit, the corporation cannot exclude this income on the Iowa corporation income tax return because the corporation has claimed the film qualified expenditure tax credit.

53.25(2) *Projects registered on or after July 1, 2009.* For tax years beginning on or after July 1, 2009, a taxpayer that is an Iowa-based business 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 corporation income tax return for each of the tax years 2010-2013.

53.25(3) *Repeal of exclusion.* The exclusion of income from the sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects is repealed for tax years beginning on or after January 1, 2012. However, the exclusion is still available if the contract or agreement related to a film project was entered into on or before May 25, 2012. Assuming the same facts as those in the example in subrule 53.25(2), the taxpayer may continue to exclude \$2,500

of income on the Iowa corporation income tax return for the 2012 and 2013 tax years since the contract or agreement was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40, and Iowa Code section 422.35 as amended by 2012 Iowa Acts, House File 2337, section 35.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 0398C, IAB 10/17/12, effective 11/21/12]

701—53.26(422) Exclusion of biodiesel production refund. A taxpayer may exclude, to the extent included in federal taxable income, the amount of the biodiesel production refund described in rule 701—12.18(423).

This rule is intended to implement Iowa Code section 422.35 as amended by 2011 Iowa Acts, Senate File 531.

[ARC 9821B, IAB 11/2/11, effective 12/7/11]

701—53.27(422) Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020.

53.27(1) In general. Public Law 115-97, Section 13303, repealed the deferral of gain or loss from exchanges of like-kind personal property for federal purposes under Section 1031 of the Internal Revenue Code. This federal repeal applies to exchanges completed after December 31, 2017, unless the taxpayer began the exchange by transferring personal property or receiving replacement personal property on or before that date. Iowa did not conform to this federal repeal for Iowa corporation income tax purposes for tax periods beginning before January 1, 2019. For tax years beginning on or after January 1, 2019, but before January 1, 2020, Iowa generally conforms to the federal treatment of gain or loss from exchanges of like-kind personal property, but eligible taxpayers may elect the treatment that applied under prior federal law for Iowa purposes. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal treatment for these exchanges, and no special election is available. This rule governs exchanges of like-kind personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020. This rule does not apply to exchanges completed during any tax year beginning on or after January 1, 2020.

53.27(2) Qualification. Section 1031 of the Internal Revenue Code in effect on December 21, 2017, and any applicable federal regulations govern whether transactions involving the disposition and acquisition of personal property qualify for Iowa corporate income tax purposes as a like-kind exchange of personal property subject to the deferral of gain or loss and also govern the date and tax period during which an exchange is considered completed. The treatment of such transactions as a like-kind exchange for Iowa corporate income tax purposes is either mandatory or permissive depending on the date the like-kind exchange is completed.

a. Like-kind exchanges completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019. Transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019, are required to be treated as a like-kind exchange for Iowa corporate income tax purposes.

b. Like-kind exchanges completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020. For tax periods beginning on or after January 1, 2019, Iowa is conformed to the federal repeal of deferral of gain or loss from exchanges of like-kind personal property, so the federal and Iowa treatment of such transactions under Section 1031 of the Internal Revenue Code will generally be the same. However, transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020, may at the election of the taxpayer be treated as a like-kind exchange for Iowa corporate income tax purposes. The election is made by completing the necessary worksheets and forms and making the required adjustments on the Iowa return as described in subrule 53.27(3). No special attachment or statement is required. The election only applies to the transactions involved in the like-kind exchange, and the taxpayer may elect or not elect to treat other qualifying transactions as a like-kind exchange for Iowa purposes.

53.27(3) Calculation and Iowa adjustments. A taxpayer required to or electing to treat qualifying transactions as a like-kind exchange for Iowa tax purposes must make certain Iowa calculations and adjustments on forms and worksheets made available on the department's website. The IA 8824 Worksheet described in this subrule need not be included with the Iowa return but must be kept with the taxpayer's records. The taxpayer is responsible for providing documentation at the department's request to substantiate a like-kind exchange under this rule.

a. Like-kind exchange calculation. The taxpayer must complete Parts I and II of the IA 8824 Worksheet to compute the Iowa recognized gain, if any, the Iowa deferred gain or loss, and the Iowa basis of the like-kind personal property received in the like-kind exchange.

EXAMPLE 1: X, a corporation engaged in commercial farming and filing on a calendar-year basis, trades a tractor with a fair market value (FMV) of \$25,000 along with \$75,000 in cash to Y for a new tractor with an FMV of \$100,000. For purposes of this example it is assumed that the tractor trade occurs in 2019 and qualifies as a like-kind exchange and that X elects such treatment for Iowa corporate income tax purposes under paragraph 53.27(2) "b." At the time of the trade, the adjusted basis of X's old tractor is \$0 for federal tax purposes and is \$13,680 for Iowa tax purposes. X realizes a gain for Iowa purposes on the exchange of the old tractor in the amount of \$11,320 (\$100,000 FMV of new tractor - \$75,000 cash paid - \$13,680 Iowa adjusted basis of old tractor). Because X did not receive any cash or other property that was not like-kind, or assume any liabilities from Y, the entire amount of X's \$11,320 realized gain qualifies for deferral, so X recognizes \$0 of gain on the exchange for Iowa tax purposes. As a result, X's basis in the new tractor for Iowa tax purposes is \$88,680 (\$13,680 Iowa adjusted basis of old tractor + \$75,000 cash paid by X).

b. Iowa nonconformity adjustment.

(1) The taxpayer must complete Part III of the IA 8824 Worksheet to adjust for the difference between any recognized Iowa gain from the exchange as calculated on the IA 8824 Worksheet, Part II, and any gain or loss (including gain or loss recaptured as ordinary income) recognized on the taxpayer's federal return.

EXAMPLE 2: Assume the same facts as given in Example 1. Because the tractor trade occurred in 2019, it will not qualify as a like-kind exchange for federal tax purposes but will instead be treated as two separate transactions: a sale of the old tractor and a purchase of the new tractor. X recognizes a gain for federal tax purposes on the sale of the old tractor in the amount of \$25,000 (\$25,000 sales price of old tractor - \$0 federal adjusted basis of old tractor), the entire amount of which is recaptured as ordinary income because of prior depreciation. X reports the \$25,000 of income on the federal return. X is required to report the same \$25,000 as income on the Iowa return but is also allowed a \$25,000 subtraction on the same Iowa return because X's recognized gain for Iowa tax purposes is \$0 as calculated in Example 1. X's nonconformity adjustment of -\$25,000 must be reported on the Iowa return in the manner prescribed on the IA 8824 Worksheet.

(2) If the total recognized federal gain is reported using the installment sale method under Section 453 of the Internal Revenue Code, the total amount of any Iowa nonconformity adjustment related to that federal gain must be claimed over the same installment period, and the proportion of the total Iowa nonconformity adjustment claimed for each tax year shall equal the same proportion that the federal gain reported for that tax year bears to the total amount of federal gain that will ultimately be reported for all tax years resulting from the disposition of the personal property. The taxpayer must complete an IA 8824 Worksheet for each tax year that an Iowa nonconformity adjustment is claimed.

c. Cost recovery adjustments.

(1) The taxpayer must complete the IA 4562A to account for any differences between the federal and Iowa cost recovery deductions related to the like-kind personal property involved in the like-kind exchange, including if the taxpayer's basis in the like-kind personal property received is different for federal and Iowa purposes, or if the taxpayer claimed additional first-year depreciation or a section 179 deduction for federal purposes on the like-kind property received in the exchange. See rule 701—53.22(422) for requirements related to the disallowance of additional first-year depreciation for Iowa corporate income tax purposes. See rule 701—53.23(422) for the section 179 limitations imposed under the Iowa corporate income tax.

(2) Treasury Regulation §1.168(i)-6 prescribes rules related to the calculation of depreciation for certain assets involved in a like-kind exchange, but a taxpayer may elect to not have those rules apply pursuant to Treasury Regulation §1.168(i)-6(i). A taxpayer may choose to make a similar election under Treasury Regulation §1.168(i)-6(i) for Iowa tax purposes with regard to a like-kind exchange under this rule if the personal property otherwise would have qualified for such federal election notwithstanding the fact that no like-kind exchange occurred for federal purposes or the fact that no election was actually made for federal tax purposes in accordance with Treasury Regulation §1.168(i)-6(j). The election is made by calculating depreciation for Iowa tax purposes on the personal property involved in the like-kind exchange using the method described in Treasury Regulation §1.168(i)-6(i) on the timely filed Iowa return, including extensions, for the same tax year that the like-kind exchange was completed. No special attachment or statement is required.

EXAMPLE 3: Assume the same facts as given in Examples 1 and 2. X elects additional first-year depreciation on the new tractor and claims a depreciation deduction on the federal return of \$100,000 (100 percent of X's federal basis). X is required to add back the total amount of the federal depreciation on the Iowa return because Iowa does not allow additional first-year depreciation. But X is permitted deductions for regular depreciation on the new tractor with an Iowa basis of \$88,680 (\$13,680 carryover basis from old tractor + \$75,000 excess basis from cash paid) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). See rule 701—53.22(422) for more information on the disallowance of additional first-year depreciation.

EXAMPLE 4: Assume the same facts as given in Examples 1 and 2. X elects to expense the entire cost of the new tractor under Section 179 of the Internal Revenue Code and claims a deduction on the federal return of \$100,000. X is also required to claim the section 179 deduction on the new tractor for Iowa tax purposes pursuant to subrule 53.23(2). However, the amount that represents the carryover basis from the old tractor (\$13,680) is not eligible for the deduction under Section 179(d)(3) of the Internal Revenue Code, so the cost of the new tractor that is eligible for the section 179 deduction for Iowa purposes is only \$75,000 (excess basis from cash paid). This is the amount of section 179 deduction that X must claim on the Iowa return, subject to the applicable Iowa dollar limitation and reduction limitations in rule 701—53.23(422). Because X is the taxpayer who placed the new tractor in service, X is permitted deductions for regular depreciation on the carryover basis in the new tractor (\$13,680) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k).

This rule is intended to implement 2019 Iowa Acts, chapter 152 [House File 779], section 11. [ARC 4614C, IAB 8/14/19, effective 9/18/19]

701—53.28(422) Broadband infrastructure grant exemption.

53.28(1) *Broadband infrastructure grant exemption, generally.* For tax years beginning on or after January 1, 2019, certain qualifying communications service providers may subtract, to the extent included in income, the amount of qualifying government grants used to install broadband infrastructure that facilitates broadband service in targeted service areas at or above download and upload speeds identified by the Federal Communications Commission pursuant to Section 706 of the federal Telecommunications Act of 1996, as amended. This rule explains terms not defined in Iowa Code section 422.35.

53.28(2) *Definitions.*

“*Facilitate*” shall have the same meaning as defined in Iowa Code section 8B.1.

“*Grant*” means a transfer for a governmental purpose of money or property to a transferee that is not a related party to or an agent of the transferor. The transfer must not impose any obligation or condition to directly or indirectly repay any amount to the transferor or a related party. Obligations or conditions intended solely to assure expenditure of the transferred moneys in accordance with the governmental purpose of the transfer do not prevent a transfer from being a grant.

1. “Federal grant” means any grant issued by the United States government, including any agency or instrumentality thereof.

2. “State grant” means any grant issued by any state of the United States, the District of Columbia, or a territory or possession of the United States, including any agency or instrumentality thereof.

3. “Local grant” means any grant issued by any city, county, township, school district, or any other unit of local government, including any agency or instrumentality thereof.

53.28(3) *Limitation on certain refund claims.* For tax years beginning on or after January 1, 2019, and before January 1, 2020, refund claims resulting from this exemption must be filed prior to October 1, 2020. No refunds shall be issued for claims filed on or after that date.

This rule is intended to implement Iowa Code section 422.35.
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◊ Two or more ARCs

CHAPTER 59
DETERMINATION OF NET INCOME
[Prior to 12/17/86, Revenue Department[730]]

701—59.1(422) Computation of net income for financial institutions. “Net income” for state purposes shall mean federal taxable income, before deduction for net operating losses, as properly computed under the Internal Revenue Code, and shall include the adjustments in rules 701—59.2(422) to 701—59.13(422). The remaining provisions of this rule and rules 701—59.14(422) to 701—59.24(422) shall also be applicable in determining net income.

In the case of a financial institution which is a member of an affiliated group of corporations filing a consolidated income tax return for the taxable year for federal income tax purposes, but files a separate return for state purposes, taxable income as properly computed for federal purposes is determined as if the financial institution had filed a separate return for federal income tax purposes for the taxable year and each preceding taxable year for which it was a member of an affiliated group. For purposes of this paragraph, the taxpayer’s separate taxable income shall be determined as if the election provided by Section 243(b)(2) of the Internal Revenue Code had been in effect for all those years.

When a federal short period return is filed and the federal taxable income is required to be adjusted to an annual basis, the Iowa taxable income shall also be adjusted to an annual basis. The tax liability for a short period is computed by multiplying the taxable income for the short period by 12 and dividing the result by the number of months in the short period. The tax is determined on the resulting total as if it were the taxable income, and the tax computed is divided by 12 and multiplied by the number of months in the short period. This adjustment shall apply only to income attributable to business carried on within the state of Iowa.

This rule is intended to implement Iowa Code section 422.35.

701—59.2(422) Net operating loss carrybacks and carryovers. Net operating losses shall be allowed or allowable for Iowa franchise tax purposes to the same extent they are allowed or allowable for federal corporation income tax purposes, provided the following adjustments are made:

59.2(1) Additions to income.

a. Refunds of federal income taxes due to net operating loss, capital loss and investment credit or other credit carrybacks shall not be added for tax years beginning on or after January 1, 1980.

b. Iowa franchise tax deducted on the federal return for the loss year shall be reflected as an addition to income in the year of the loss.

c. Interest and dividends received in the year of the loss on federally tax-exempt securities shall be reflected as additions to income in the year of the loss.

59.2(2) Reductions of income. Iowa franchise tax refunds reported as income for federal income tax purposes in the loss year shall be reflected as reductions of income in the year of the loss.

59.2(3) If a financial institution does business both within and without Iowa, it shall make adjustments reflecting the apportionment and allocation of its operating loss on the basis of business done within and without the state of Iowa after completing the provisions of subrules 59.2(1) and 59.2(2).

a. After making the adjustments to federal taxable income as provided in subrules 59.2(1) and 59.2(2), the total net allocable income or loss shall be added to or deducted from, as the case may be, the net federal income or loss as adjusted for Iowa tax purposes. The resulting income or loss so determined shall be subject to apportionment as provided in rules 701—59.25(422) to 701—59.29(422). The apportioned income or loss shall be added or deducted, as the case may be, to the amount of net allocable income or loss properly attributable to Iowa. This amount is the taxable income or net operating loss attributable to Iowa for that year.

b. The net operating loss attributable to Iowa, as determined in rule 701—59.2(422), shall be subject to a 3-year carryback and a 15-year carryover provision for tax years beginning before August 6, 1997. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa 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 15 taxable years. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa corporation income tax return filed with the department.

c. For tax years beginning after August 5, 1997, but before January 1, 2009, a net operating loss attributable to Iowa, as determined in rule 701—59.2(422), incurred in a presidentially declared disaster area by a corporation engaged in a small business or in the trade or business of farming must be carried back 3 taxable years and carried forward 20 taxable years. All other net operating losses attributable to Iowa must be carried back 2 taxable years and carried forward 20 taxable years. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa 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. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa franchise tax return filed with the department.

d. For tax years beginning on or after January 1, 2009, a net operating loss attributable to Iowa, as determined in rule 701—59.2(422), shall be carried forward 20 taxable years. The net operating loss cannot be carried back to a previous tax year.

59.2(4) No part of a net loss for a year for which the financial institution was not subject to the imposition of Iowa franchise 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.

59.2(5) No part of a net operating loss may be carried back or carried forward if the carryback or carryforward would be disallowed for federal income tax purposes under Sections 172(b)(1)(E) and 172(h) of the Internal Revenue Code. This provision is effective for tax years beginning on or after January 1, 1989.

59.2(6) The carryover of Iowa net operating losses after reorganizations or mergers is limited to the same extent as the carryover of a net operating loss is limited under the provisions of Sections 381 through 386 of the Internal Revenue Code and regulations thereunder or any other section of the Internal Revenue Code or regulations thereunder. Where the taxpayer files as a member of a consolidated income tax return for federal income tax purposes, but is required to file a separate franchise tax return, the limitation on an Iowa net operating loss carryover must be determined as though a separate income tax return was filed for federal income tax purposes.

This rule is intended to implement Iowa Code section 422.35 as amended by 2009 Iowa Acts, Senate File 483, and sections 422.61 and 422.63.

[ARC 8589B, IAB 3/10/10, effective 4/14/10]

701—59.3(422) Capital loss carryback. Capital losses shall be allowed or allowable for Iowa franchise tax purposes to the same extent they are allowed or allowable for federal corporation income tax purposes. Capital loss carrybacks shall be treated as an adjustment to federal taxable income to arrive at net income. For capital losses occurring in tax years beginning on or after January 1, 1980, refunds of federal corporation income taxes shall not be an adjustment in computing income subject to the franchise tax.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.4(422) Net operating and capital loss carrybacks and carryovers. If the taxpayer, for tax periods beginning before January 1, 2009, has both a net operating loss and a capital loss carryback to a prior tax year, the capital loss shall be carried back first and then the net operating loss offset against any remaining income.

This rule is intended to implement Iowa Code section 422.35 as amended by 2009 Iowa Acts, Senate File 483, and section 422.61.

[ARC 8589B, IAB 3/10/10, effective 4/14/10]

701—59.5(422) Interest and dividends from federal securities. For franchise tax purposes, dividends received from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies and instrumentalities become a part of the taxable income. Examples of these types of obligations are bonds issued by the governments of Puerto Rico, Washington D.C., Guam and the Virgin Islands. Notwithstanding the above, only interest received after July 1, 1991, from bonds purchased after January 1, 1991, issued by the governments of Puerto Rico, Guam and the Virgin Islands is subject to tax.

Gains or losses from the sale or other disposition of any bonds shall be taxable for state franchise tax purposes.

Interest received on federal tax refunds is taxable for Iowa franchise tax purposes.

This rule is intended to implement Iowa Code section 422.61.

701—59.6(422) Interest and dividends from foreign securities and securities of states and other political subdivisions. Interest and dividends from foreign securities and securities of states and their political subdivisions including Iowa shall be included in taxable income for periods beginning on or after January 1, 1980. For tax periods beginning on or after January 1, 1987, subtract interest expense allocable to interest exempt from federal income tax which was disallowed as a deduction under Internal Revenue Code Section 265(b) or 291(e)(1)(B).

For tax years beginning on or after January 1, 1987, add dividends received from regulated investment companies exempt from federal income tax under Section 852(b)(5) of the Internal Revenue Code and subtract the loss on the sale or exchange of a share of a regulated investment company held for six months or less to the extent the loss was disallowed under Section 852(b)(4)(B) of the Internal Revenue Code.

For tax years beginning on or after January 1, 2001, add, to the extent not already included, income from the sale of obligations of the state of Iowa and its political subdivisions and interest and dividend income from these obligations. Gains or losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions, along with interest and dividend income from these bonds, shall be included in Iowa taxable income unless the law authorizing these obligations specifically exempts the income from the sale and interest and dividend income from Iowa franchise tax.

This rule is intended to implement Iowa Code sections 422.35 and 422.61 as amended by 2001 Iowa Acts, House File 715.

701—59.7(422) Safe harbor leases. For tax years ending after January 1, 1981, deductions in determining federal taxable income for sale-leaseback agreements taken as a result of the application of Section 168(f)(8) of the Internal Revenue Code shall be added in determining Iowa taxable income to the extent such deductions cannot be taken under provisions of Sections 162, 163 and 167 of the Internal Revenue Code. The lessor shall add depreciation and interest expense, and the lessee shall add rental expense. When the deduction for depreciation is not allowed under a previous provision of this rule, the lessee shall be allowed a deduction for depreciation on any property involved in a sale-leaseback agreement. The depreciation shall be computed in accordance with Section 168(a) of the Internal Revenue Code. Income received as a result of sale-leaseback agreement shall be deducted in determining Iowa taxable income. The lessee shall deduct interest income and the lessor shall deduct rent income. Each lessor and lessee corporation shall include a copy of federal Form 6793 in its Iowa franchise tax return for the year in which a safe harbor lease is entered into.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.8(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, a taxpayer which is considered to be a small business corporation, as defined by subrule 59.8(2), is allowed a deduction for 50 percent of the first 12 months of wages paid or accrued during the tax years for work done in Iowa for employees first hired on or after January 1, 1984.

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 904, division IX.

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 907A.1 applies.

For tax years beginning on or after January 1, 1989, a taxpayer which is considered to be a small business corporation, as defined by 701—subrule 53.11(2), is allowed a deduction for 65 percent not to exceed \$20,000 of the 12 months of wages paid or accrued during the tax year for work done in Iowa for employees first hired after January 1, 1989, who meet the above criteria.

59.8(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 division of job service of the department of employment services, 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.

59.8(2) The term "small business corporation" includes the operation of a farm but does not include the practice of a profession. The following conditions apply for the purpose of determining what constitutes a small business corporation.

a. A small business corporation shall not have had more than 20 full-time equivalent positions during each of the 26 consecutive weeks within the 52-week period immediately preceding the date on which the 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:

<u>Average Number of Weekly Hours</u>	<u>Category</u>
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. A small business corporation 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 interest received from loans and investments, service charges, management fees, fiduciary fees, commissions, and gross proceeds from the sale of securities held as investments as determined in accordance with generally accepted accounting principles.

c. A small business corporation 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.

59.8(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 intellectual disability, 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.

59.8(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 targeted jobs tax credit under Section 59 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.

59.8(5) The taxpayer shall include a schedule with the filing of the taxpayer's tax return showing the name, address, social security number, date of hiring and wages paid of each employee for whom the taxpayer claims the additional deduction for wages.

59.8(6) If the employee for whom an additional deduction for wages was allowed fails to successfully complete a probationary period and the taxpayer has already filed an Iowa corporation 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.

59.8(7) For tax years ending after July 1, 1990, a taxpayer who did not qualify for the additional deduction for wages paid or accrued for work done in Iowa by certain individuals set forth above is allowed an additional deduction of 65 percent not to exceed \$20,000 of the first 12 months of wages paid or accrued for work done in Iowa for employees first hired on or after July 1, 1990, if the new employee is:

a. An individual domiciled in this state at the time of the 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 904, division IX.

b. 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 907A.1 applies.

The additional deduction is not 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 Iowa division of job service of the department of employment services, the additional deduction is allowed.

The taxpayer must include a schedule with the filing of the taxpayer's tax return showing the name, address, social security number, date of hiring, and wages paid of each employee for whom the taxpayer claims the additional deduction for wages.

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.

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 franchise tax return taking the additional deduction for wages, the taxpayer must file an amended return adding back the additional deduction for wages. The amended return must 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 16.1 and 2011 Iowa Code Supplement section 422.35 as amended by 2012 Iowa Acts, Senate File 2247.
[ARC 0337C, IAB 9/19/12, effective 10/24/12]

701—59.9(422) Work opportunity tax credit. Where a financial institution claims the federal work opportunity tax credit as provided in Section 51 of the Internal Revenue Code, the amount of credit

allowable shall be a deduction from Iowa taxable income to the extent the credit increased federal taxable income.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.10(422) Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020.

59.10(1) *In general.* Public Law 115-97, Section 13303, repealed the deferral of gain or loss from exchanges of like-kind personal property for federal purposes under Section 1031 of the Internal Revenue Code. This federal repeal applies to exchanges completed after December 31, 2017, unless the taxpayer began the exchange by transferring personal property or receiving replacement personal property on or before that date. Iowa did not conform to this federal repeal for Iowa franchise tax purposes for tax periods beginning before January 1, 2019. For tax years beginning on or after January 1, 2019, but before January 1, 2020, Iowa generally conforms to the federal treatment of gain or loss from exchanges of like-kind personal property, but eligible taxpayers may elect the treatment that applied under prior federal law for Iowa purposes. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal treatment for these exchanges, and no special election is available. This rule governs exchanges of like-kind personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020. This rule does not apply to exchanges completed during any tax year beginning on or after January 1, 2020.

59.10(2) *Qualification.* Section 1031 of the Internal Revenue Code in effect on December 21, 2017, and any applicable federal regulations govern whether transactions involving the disposition and acquisition of personal property qualify for Iowa franchise tax purposes as a like-kind exchange of personal property subject to the deferral of gain or loss and also govern the date and tax period during which an exchange is considered completed. The treatment of such transactions as a like-kind exchange for Iowa franchise tax purposes is either mandatory or permissive depending on the date the like-kind exchange is completed.

a. Like-kind exchanges completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019. Transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed after December 31, 2017, but before tax periods beginning on or after January 1, 2019, are required to be treated as a like-kind exchange for Iowa franchise tax purposes.

b. Like-kind exchanges completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020. For tax periods beginning on or after January 1, 2019, Iowa is conformed to the federal repeal of deferral of gain or loss from exchanges of like-kind personal property, so the federal and Iowa treatment of such transactions under Section 1031 of the Internal Revenue Code will generally be the same. However, transactions involving the disposition and acquisition of personal property that qualify under this subrule as a like-kind exchange completed during tax periods beginning on or after January 1, 2019, but before January 1, 2020, may at the election of the taxpayer be treated as a like-kind exchange for Iowa franchise tax purposes. The election is made by completing the necessary worksheets and forms and making the required adjustments on the Iowa return as described in subrule 59.10(3). No special attachment or statement is required. The election only applies to the transactions involved in the like-kind exchange, and the taxpayer may elect or not elect to treat other qualifying transactions as a like-kind exchange for Iowa purposes.

59.10(3) *Calculation and Iowa adjustments.* A taxpayer required to or electing to treat qualifying transactions as a like-kind exchange for Iowa tax purposes must make certain Iowa calculations and adjustments on forms and worksheets made available on the department's website. The IA 8824 Worksheet described in this subrule need not be included with the Iowa return but must be kept with the taxpayer's records. The taxpayer is responsible for providing documentation at the department's request to substantiate a like-kind exchange under this rule.

a. Like-kind exchange calculation. The taxpayer must complete Parts I and II of the IA 8824 Worksheet to compute the Iowa recognized gain, if any, the Iowa deferred gain or loss, and the Iowa basis of the like-kind personal property received in the like-kind exchange.

EXAMPLE 1: X, a financial institution filing on a calendar-year basis, trades a computer system with a fair market value (FMV) of \$25,000 along with \$75,000 in cash to Y for a new computer system with an FMV of \$100,000. For purposes of this example it is assumed that the computer system trade occurs in 2019 and qualifies as a like-kind exchange and that X elects such treatment under paragraph 59.10(2) “b.” At the time of the trade, the adjusted basis of X’s old computer system is \$0 for federal tax purposes and is \$13,680 for Iowa tax purposes. X realizes a gain for Iowa purposes on the exchange of the old computer system in the amount of \$11,320 (\$100,000 FMV of new computer system - \$75,000 cash paid - \$13,680 Iowa adjusted basis of old computer system). Because X did not receive any cash or other property that was not like-kind, or assume any liabilities from Y, the entire amount of X’s \$11,320 realized gain qualifies for deferral, so X recognizes \$0 of gain on the exchange for Iowa tax purposes. As a result, X’s basis in the new computer system for Iowa tax purposes is \$88,680 (\$13,680 Iowa adjusted basis of old computer system + \$75,000 cash paid by X).

b. Iowa nonconformity adjustment.

(1) The taxpayer must complete Part III of the IA 8824 Worksheet to adjust for the difference between any recognized Iowa gain from the exchange as calculated on the IA 8824 Worksheet, Part II, and any gain or loss (including gain or loss recaptured as ordinary income) recognized on the taxpayer’s federal return.

EXAMPLE 2: Assume the same facts as given in Example 1. Because the computer trade occurred in 2019, it will not qualify as a like-kind exchange for federal tax purposes but will instead be treated as two separate transactions: a sale of the old computer system and a purchase of the new computer system. X recognizes a gain for federal tax purposes on the sale of the old computer system in the amount of \$25,000 (\$25,000 sales price of old computer system - \$0 federal adjusted basis of old computer system), the entire amount of which is recaptured as ordinary income because of prior depreciation. X reports the \$25,000 of income on the federal return. X is required to report the same \$25,000 as income on the Iowa return but is also allowed a \$25,000 subtraction on the same Iowa return because X’s recognized gain for Iowa tax purposes is \$0 as calculated in Example 1. X’s nonconformity adjustment of -\$25,000 must be reported on the Iowa return in the manner prescribed on the IA 8824 Worksheet.

(2) If the total recognized federal gain is reported using the installment sale method under Section 453 of the Internal Revenue Code, the total amount of any Iowa nonconformity adjustment related to that federal gain must be claimed over the same installment period, and the proportion of the total Iowa nonconformity adjustment claimed for each tax year shall equal the same proportion that the federal gain reported for that tax year bears to the total amount of federal gain that will ultimately be reported for all tax years resulting from the disposition of the personal property. The taxpayer must complete an IA 8824 Worksheet for each tax year that an Iowa nonconformity adjustment is claimed.

c. Cost recovery adjustments.

(1) The taxpayer must complete the IA 4562A to account for any differences between the federal and Iowa cost recovery deductions related to the like-kind personal property involved in the like-kind exchange, including if the taxpayer’s basis in the like-kind personal property received is different for federal and Iowa purposes, or if the taxpayer claimed additional first-year depreciation or a section 179 deduction for federal purposes on the like-kind property received in the exchange. See rule 701—59.23(422) for requirements related to the disallowance of additional first-year depreciation for Iowa franchise tax purposes. See rule 701—59.24(422) for the section 179 limitations imposed under the Iowa franchise tax.

(2) Treasury Regulation §1.168(i)-6 prescribes rules related to the calculation of depreciation for certain assets involved in a like-kind exchange, but a taxpayer may elect to not have those rules apply pursuant to Treasury Regulation §1.168(i)-6(i). A taxpayer may choose to make a similar election under Treasury Regulation §1.168(i)-6(i) for Iowa tax purposes with regard to a like-kind exchange under this rule if the personal property otherwise would have qualified for such federal election notwithstanding the fact that no like-kind exchange occurred for federal purposes or the fact that no election was actually made for federal tax purposes in accordance with Treasury Regulation §1.168(i)-6(j). The election is made by calculating depreciation for Iowa tax purposes on the personal property involved in the like-kind exchange using the method described in Treasury Regulation §1.168(i)-6(i) on the timely filed Iowa

return, including extensions, for the same tax year that the like-kind exchange was completed. No special attachment or statement is required.

EXAMPLE 3: Assume the same facts as given in Examples 1 and 2. X elects additional first-year depreciation on the new computer system and claims a depreciation deduction on the federal return of \$100,000 (100 percent of X's federal basis). X is required to add back the total amount of the federal depreciation on the Iowa return because Iowa does not allow additional first-year depreciation. But X is permitted deductions for regular depreciation on the new computer system with an Iowa basis of \$88,680 (\$13,680 carryover basis from old computer system + \$75,000 excess basis from cash paid) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). See rule 701—59.23(422) for more information on the disallowance of additional first-year depreciation.

EXAMPLE 4: Assume the same facts as given in Examples 1 and 2. X elects to expense the entire cost of the new computer system under Section 179 of the Internal Revenue Code and claims a deduction on the federal return of \$100,000. X is also required to claim the section 179 deduction on the new computer system for Iowa tax purposes pursuant to subrule 59.24(2). However, the amount that represents the carryover basis from the old computer system (\$13,680) is not eligible for the deduction under Section 179(d)(3) of the Internal Revenue Code, so the cost of the new computer system that is eligible for the section 179 deduction for Iowa purposes is only \$75,000 (excess basis from cash paid). This is the amount of section 179 deduction that X must claim on the Iowa return, subject to the applicable Iowa dollar limitation and reduction limitations in rule 701—59.24(422). Because X is the taxpayer who placed the new computer system in service, X is permitted deductions for regular depreciation on the carryover basis in the new computer system (\$13,680) under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k).

This rule is intended to implement 2019 Iowa Acts, chapter 152 [House File 779], section 11.
[ARC 4614C, IAB 8/14/19, effective 9/18/19]

701—59.11(422) Gains and losses on property acquired before January 1, 1934. Where 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. *City National Bank of Clinton v. Iowa State Tax Commission*, 251 Iowa 603, 102 N.W.2d 381 (1960).

If as a result of this provision a basis is to be used for purposes of Iowa franchise tax which is different from the basis used for purposes of federal income tax, an appropriate adjustment must be made and detailed schedules supplied in the computation of Iowa income subject to franchise tax.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.12(422) Federal income tax deduction. For tax years beginning on or after January 1, 1980, a deduction for 50 percent of federal income taxes paid or accrued is not allowed. Cash-basis taxpayers are not allowed a deduction for 50 percent of federal income taxes paid during a tax year beginning on or after January 1, 1980, which represent the preceding year's tax or additional taxes for prior years. Fifty percent of a federal income tax refund received during a tax year beginning on or after January 1, 1980, shall not be reported as income. For tax years beginning on or after January 1, 1990, because the federal environmental tax is deducted in computing federal taxable income and Iowa Code section 422.61(3)“a” does not allow the deduction of federal income taxes, the federal environmental tax must be added to federal taxable income.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.13(422) Iowa franchise taxes. Iowa franchise taxes paid or accrued during the tax year as may be applicable under the method of filing are permissible deductions for federal corporation income tax purposes, but not for purposes of determining Iowa net income. To the extent taxes were deducted in the determination of federal taxable income, they shall be added to federal taxable income for Iowa

franchise tax purposes. Refunds of Iowa franchise tax to the extent that the returns are included in the determination of federal taxable income shall all be subtracted from federal taxable income.

This rule is intended to implement Iowa Code section 422.61.

701—59.14(422) Method of accounting, accounting period. The return shall be computed on the same basis and for the same accounting period as the taxpayer's return for federal corporation income tax purposes. Permission to change accounting methods or accounting periods for franchise tax purposes is not required provided the taxpayer furnishes the department with a copy of the federal consent.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.15(422) Consolidated returns. There is no provision in the Iowa franchise tax law to allow financial institutions to file consolidated Iowa franchise tax returns with another financial institution or another corporation as defined in Iowa Code section 422.32. In the absence of any statutory authority for allowing consolidated Iowa franchise tax returns, separate Iowa franchise tax returns must be filed.

This rule is intended to implement Iowa Code sections 421.14 and 422.68(1).

701—59.16(422) Federal rulings and regulations. In determining whether "taxable income," "net operating loss deduction" or any other deductions are computed for federal tax purposes under, or have the same meaning as provided by, the Internal Revenue Code, the department will use applicable rulings and regulations that have been duly promulgated by the Commissioner of Internal Revenue, unless the director has created rules and regulations or has exercised discretionary powers as prescribed by statute which call for an alternative method for determining "taxable income," "net operating loss deduction," or any other deductions, or unless the department finds that an applicable Internal Revenue ruling or regulation is unauthorized according to the Iowa Code.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

701—59.17(15E,422) Charitable contributions relating to the endow Iowa tax credit. For tax years beginning on or after January 1, 2010, a taxpayer who claims an endow Iowa tax credit in accordance with rule 701—58.13(15E,422) cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes.

This rule is intended to implement Iowa Code section 15E.305.

[ARC 1303C, IAB 2/5/14, effective 3/12/14]

701—59.18(422) Depreciation of speculative shell buildings.

59.18(1) For tax years beginning on or after July 1, 1992, speculative shell buildings constructed or reconstructed after that date may be depreciated as 15-year property under the accelerated cost of 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 federal taxable income in order to deduct depreciation under this rule.

59.18(2) On sale or other disposition of the speculative shell building, the taxpayer must report on the taxpayer's Iowa corporation income tax return the same gain or loss reported on the taxpayer's federal corporation 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.

59.18(3) For the purposes of this rule, the term "speculative shell building" means a building as defined in Iowa Code section 427.1, subsection (27) "c."

This rule is intended to implement Iowa Code sections 422.35 and 422.63.

701—59.19(422) Deduction of multipurpose vehicle registration fee. For tax years beginning on or after January 1, 1992, and before January 1, 2005, corporations may claim a deduction for 60 percent of the amount of the registration fee paid for a multipurpose vehicle under Iowa Code section 321.124,

subsection 3, paragraph “h.” In order to qualify for this deduction, no part of the multipurpose vehicle registration fee may have been deducted as an ordinary and necessary business expense.

For tax years beginning on or after January 1, 2005, the deduction for Iowa franchise tax for multipurpose vehicle registration fees is the same as allowed under Section 164 of the Internal Revenue Code for federal tax purposes.

This rule is intended to implement Iowa Code section 422.35.

701—59.20(422) Disallowance of expenses to carry an investment subsidiary for tax years which begin on or after January 1, 1995. A financial institution which has an investment in an investment subsidiary on or after July 1, 1995, must allocate a portion of its total expenses used in computing its federal taxable income on a separate return basis to its investment subsidiary. The expenses which are allocable to the investment in an investment subsidiary are computed by multiplying the financial institution’s total expenses used in computing its federal taxable income on a separate return basis by the ratio of the average adjusted basis in its investment subsidiary to the average adjusted basis for all assets of the financial institution. For tax years beginning on or after January 1, 1995, and before December 31, 1995, a financial institution which has an investment in an investment subsidiary on July 1, 1995, must allocate a portion of its total expenses for the entire tax year to its investment in an investment subsidiary even though it did not have an investment in an investment subsidiary for the entire tax year.

A calculation of the average for the tax year of the adjusted bases of a financial institution’s investment in investment subsidiaries, and total assets, held each day of the tax year is the most accurate method for determining under Iowa Code subsection 422.61(3) the portion of a financial institution’s total expenses that is allocable to the financial institution’s investment in investment subsidiaries. However, the department will generally allow the average adjusted bases of an investment in investment subsidiaries for the tax year to be calculated using the average of the adjusted bases of the investment in investment subsidiaries held by the financial institution at the end of each month within the tax year. The department generally will allow the average bases of all assets of the financial institution for the tax year to be calculated using the average bases of all assets held by the financial institution at the end of each quarter of the tax year. A financial institution may compute for any tax year, without prior permission of the director, the average adjusted bases of investment in investment subsidiaries or total assets on a more frequent basis than set forth above. However, a financial institution may not compute these averages for any tax year on a less frequent basis than quarterly without obtaining prior approval of the director. This permission will be granted only in extraordinary circumstances. In addition, a financial institution may not compute these averages for any tax year on a less frequent basis than it used for the preceding tax year unless the financial institution obtains prior approval of the director. A financial institution that has elected to use an estimate of the adjusted tax bases of its total assets for each of the first three quarters of the taxable year under Internal Revenue Service’s Revenue Ruling 90-44 for federal income tax purposes may use this estimate for Iowa franchise purposes.

59.20(1) For the purposes of this rule, the term “affiliate” means a corporation, trust, estate, association, or similar organization:

a. Of which a financial institution, directly or indirectly, owns or controls either a majority of the voting shares or more than 50 percent of the number of shares voted for the election of its directors, trustees, or other individuals exercising similar functions at the preceding election, or controls in any manner the election of a majority of its directors, trustees, or other individuals exercising similar functions; or

b. Of which control is held, directly or indirectly, through share ownership or in any other manner, by the shareholders of a financial institution who own or control either a majority of the shares of such financial institution or more than 50 percent of the number of shares voted for election of directors of such financial institution at the preceding election, or by trustees for the benefit of the shareholders of such financial institution; or

c. Of which a majority of its directors, trustees, or other individuals exercising similar functions are directors of any financial institution; or

d. Which owns or controls, directly or indirectly, either a majority of the voting shares of a financial institution or more than 50 percent of the number of shares voted for the election of directors of a financial institution at the preceding election, or controls in any manner the election of a majority of the directors of a financial institution, or for the benefit of those shareholders or members all or substantially all of the outstanding voting shares of a financial institution is held by trustees; or

e. Which is a bank holding company, as defined by the laws of the United States, of which a financial institution is a subsidiary, and any other subsidiary as defined by the laws of the United States, of a bank holding company.

59.20(2) For the purposes of this rule, the term “average adjusted basis” means the financial institution’s average adjusted basis as computed pursuant to Section 1016 of the Internal Revenue Code on a separate company basis.

59.20(3) For purposes of this rule, the term “investment subsidiary” means an affiliate that is owned, capitalized or utilized by a financial institution with one of its purposes being to make, hold, or manage, for and on behalf of the financial institution, investments in securities which the financial institution would be permitted by applicable law to make for its own account.

This rule is intended to implement Iowa Code section 422.61 as amended by 1995 Iowa Acts, chapter 193.

701—59.21(422) S corporation and limited liability company financial institutions. For tax years beginning on or after January 1, 1997, a financial institution as defined in Section 581 of the Internal Revenue Code which has in effect an election under Subchapter S of the Internal Revenue Code must compute an amount of income as if the financial institution were subject to federal corporation income tax. For tax years beginning on or after July 1, 2004, a financial institution organized as a limited liability company under Iowa Code chapter 524 that is taxed as a partnership for federal income tax purposes must compute an amount of income as if the financial institution were subject to federal corporation income tax. The income is to be computed in the same manner as a financial institution that is subject to or liable for federal income tax under the Internal Revenue Code in effect for the applicable tax would compute its federal taxable income.

This rule is intended to implement Iowa Code section 422.61 as amended by 2004 Iowa Acts, House File 2484.

701—59.22(422) 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, any gift, grant, or donation to the endowment fund of the Iowa educational savings plan trust may be deducted for Iowa franchise tax purposes. 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 sections 422.35 as amended by 1998 Iowa Acts, House File 2119, and 422.61.

701—59.23(422) Additional first-year depreciation allowance.

59.23(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 franchise 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.

59.23(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 franchise tax. If the taxpayer elects to take the 50 percent bonus depreciation, the depreciation deduction allowed on the Iowa franchise 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.

See 701—subrule 40.60(2), paragraph “a,” for examples illustrating how this subrule is applied.

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.

59.23(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 110-185, Section 103, and Public Law 111-5, Section 1201, does not apply for Iowa franchise 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.

59.23(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 franchise 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.

59.23(5) *Assets acquired after December 31, 2009, but before January 1, 2014.* For tax periods beginning after December 31, 2009, but beginning before January 1, 2014, the bonus depreciation authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 111-240, Section 2022, Public Law No. 111-312, Section 401, and Public Law No. 112-240, Section 331, does not apply for Iowa franchise 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, 2014, 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, 2014, 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 422.35 as amended by 2013 Iowa Acts, Senate File 106, and section 422.61.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13]

701—59.24(422) Section 179 expensing.

59.24(1) *In general.* Iowa taxpayers that elect to expense certain depreciable business assets in the year the assets were placed in service under Section 179 of the Internal Revenue Code must also expense those same assets for Iowa income tax purposes in that year. However, for certain years, the Iowa limitations on this deduction are different from the federal limitations for the same year. This means that for some tax years, adjustments are required to determine the correct Iowa section 179 expensing deduction, as described in this rule.

59.24(2) *Claiming the deduction.*

a. Timing and requirement to follow federal election. A taxpayer that takes a federal section 179 deduction must also take the deduction for the same asset in the same year for Iowa purposes, except as expressly provided by Iowa law or this rule. A taxpayer that takes a federal section 179 deduction is not permitted to opt out of taking the same deduction for Iowa purposes. A taxpayer that does not take a federal section 179 deduction on a specific qualifying asset is not permitted to take a section 179 deduction for Iowa purposes on that asset.

b. Qualifying for the deduction. Whether a specific business asset qualifies for a section 179 deduction is determined by the Internal Revenue Code (Title 26, U.S. Code) and applicable federal regulations for both federal and Iowa purposes.

c. Amount of the Iowa deduction. Generally, the Iowa deduction must equal the amount of the federal deduction taken for the same asset in the same year, subject to special Iowa limitations. The following chart provides a comparison of the Iowa and federal section 179 dollar limitations and reduction limitations. See rule 701—40.65(422) for the section 179 rules applicable to individuals

and other noncorporate entities, and see rule 701—53.23(422) for the section 179 rules applicable to corporations (both C and S corporations) and other entities subject to the corporate income tax.

Section 179 Deduction Allowances Under Federal and Iowa Law				
	Federal		Iowa	
Tax Year	Dollar Limitation	Reduction Limitation	Dollar Limitation	Reduction Limitation
2003	\$ 100,000	\$ 400,000	\$ 100,000	\$ 400,000
2004	102,000	410,000	102,000	410,000
2005	105,000	420,000	105,000	420,000
2006	108,000	430,000	108,000	430,000
2007	125,000	500,000	125,000	500,000
2008	250,000	800,000	250,000	800,000
2009	250,000	800,000	133,000	530,000
2010	500,000	2,000,000	500,000	2,000,000
2011	500,000	2,000,000	500,000	2,000,000
2012	500,000	2,000,000	500,000	2,000,000
2013	500,000	2,000,000	500,000	2,000,000
2014	500,000	2,000,000	500,000	2,000,000
2015	500,000	2,000,000	500,000	2,000,000
2016	500,000	2,010,000	25,000	200,000
2017	510,000	2,030,000	25,000	200,000
2018	1,000,000	2,500,000	70,000	280,000
2019	1,020,000	2,550,000	100,000	400,000
2020 and later	Iowa limitations are the same as federal			

d. Reduction. Both the federal and the Iowa deductions for section 179 assets are reduced (phased out dollar for dollar) for taxpayers whose total section 179 assets placed in service during a given year cost more than the amount specified (reduction limitation) for that year. Like the deduction limitation, the Iowa and federal reduction limitations are different for certain years. See paragraph 59.24(2) “c” for applicable limitations.

EXAMPLE: Taxpayer, a financial institution doing business in Iowa, purchases \$400,000 worth of qualifying section 179 assets and places all of them in service in 2018. Taxpayer claims a section 179 deduction of \$400,000 for the full cost of the assets on the 2018 federal return. For financial institutions, the Iowa section 179 deduction for 2018 is phased out dollar for dollar by the amount of section 179 assets placed in service in excess of \$280,000. This means that for 2018, the Iowa deduction is fully phased out if the taxpayer placed in service section 179 assets that cost, in total, more than \$350,000. Since the cost of the qualifying assets in this example exceeds the Iowa section 179 phase-out limit, the taxpayer cannot claim any section 179 deduction on the Iowa return. However, the taxpayer may depreciate the entire cost of the assets for Iowa purposes.

e. Amounts in excess of the Iowa limits.

(1) Recovering the excess. Due to the differences between the Iowa and federal limitations for certain years, taxpayers may have a federal section 179 deduction that exceeds the amount allowed for Iowa purposes. This excess amount is handled in different ways depending on the source of the deduction.

1. Assets placed in service by the taxpayer or entity reporting the deduction. The cost of any section 179 assets placed in service by the taxpayer in excess of the Iowa limitation for a given year may be recovered through regular depreciation under Section 168 of the Internal Revenue Code, without regard to bonus depreciation under Section 168(k). The Iowa section 179 and depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa and federal law are calculated and tracked on forms made available on the department’s website.

EXAMPLE: Taxpayer, a financial institution doing business in Iowa, purchases a \$100,000 piece of equipment and places it in service in 2018. Taxpayer claims a section 179 deduction of \$100,000 for the full cost of the equipment on the 2018 federal return. Taxpayer is also required to claim a section 179 deduction of \$70,000 on the 2018 Iowa return (the full amount of the federal deduction up to the Iowa limit for financial institutions for 2018). The taxpayer can depreciate the remaining \$30,000 cost of the equipment for Iowa purposes.

2. Special election for assets placed in service by a pass-through entity when the section 179 deduction is claimed by an owner of that pass-through. See subrule 59.24(3) for information on a special election available to certain owners of pass-through entities related to any section 179 deductions passed through from a partnership or other entity that, in the aggregate, exceed the Iowa limitations.

(2) Special information for pass-throughs. In the case of pass-through entities, section 179 limitations apply at both the entity level and the owner level. Pass-through entities that are required to file an Iowa return and that actually place section 179 assets in service should follow 59.24(2)“e”(1)“1” to account for any assets for which the total federal section 179 deductions for a given year exceeded the Iowa limitation. Owners of pass-throughs receiving section 179 deductions from one or more pass-throughs that, in the aggregate, exceed the Iowa limitations should follow 59.24(2)“e”(1)“2.”

EXAMPLE: Bank A (a financial institution doing business exclusively in Iowa) owns 50 percent interests in each of three partnerships: C, D, and E. Partnership C, which also does business exclusively in Iowa, places \$200,000 worth of section 179 assets in service during tax year 2019 and claims a federal section 179 deduction for the full cost of the assets. Because C is required to file an Iowa partnership return, C is subject to the Iowa section 179 limitations for 2019 and must adjust its Iowa section 179 deduction as provided in 701—numbered paragraph 40.65(2)“e”(1)“1.” C passes through 50 percent of its section 179 deduction (\$100,000 for federal purposes, \$50,000 for Iowa purposes) to Bank A. Bank A also receives \$50,000 each in section 179 deductions from D and E, for a total of \$150,000 in section 179 deductions (for Iowa purposes) in 2019. Bank A is subject to the \$100,000 Iowa section 179 deduction limitation for 2019, but because Bank A received total section 179 deductions from one or more pass-throughs in excess of the 2019 Iowa limitation, Bank A is eligible for the special election referenced in 59.24(2)“e”(1)“2.”

f. Income limitation. The Iowa section 179 deduction for any given year is limited to the taxpayer’s income from active conduct in a trade or business in the same manner that the section 179 deduction is limited for federal purposes. If an allowable Iowa section 179 deduction exceeds the taxpayer’s business income for a given year, any excess allowable Iowa section 179 deduction may be carried forward as described in paragraph 59.24(2)“g.”

g. Carryforward. This paragraph applies only to amounts that do not exceed the Iowa section 179 deduction limitations for a given year but do exceed the taxpayer’s business income for that year. As with the federal deduction, allowable Iowa section 179 deductions claimed in a given year that exceed a taxpayer’s business income may be carried forward and claimed in future years. This carryforward, if any, is calculated using only amounts up to the Iowa limit. Any federal section 179 deduction the taxpayer claimed in excess of the Iowa limit is not an Iowa section 179 deduction and therefore is not eligible for the carryforward described in this paragraph. Such amounts must instead be recovered as described in paragraph 59.24(2)“e,” or in subrule 59.24(3) for taxpayers receiving the deduction from one or more pass-through entities and making the special election as described in that subrule.

h. Difference in basis. Iowa adjustments for differences between the Iowa and federal section 179 deduction limitations may cause the taxpayer to have a different basis in the same asset for Iowa and federal purposes. Taxpayers are required to use forms made available on the department’s website to calculate and track these differences.

59.24(3) Section 179 deduction received from a pass-through entity. In some cases, a financial institution that receives income from one or more pass-through entities may receive a section 179 deduction in excess of the Iowa deduction limitation listed in paragraph 59.24(2)“c” for a given year. The financial institution may be eligible for a special election with regard to that excess section 179 deduction, as described in this subrule.

a. Tax years beginning before January 1, 2018. For tax years beginning before January 1, 2018, the amount of any section 179 deduction received by a financial institution subject to the franchise tax in excess of the Iowa deduction limitation for that year is not eligible for the special election.

b. Special election available for tax years 2018 and 2019. For tax years beginning on or after January 1, 2018, but before January 1, 2020, a financial institution subject to the franchise tax that receives a section 179 deduction from one or more pass-through entities in excess of the Iowa deduction limitation for that tax year may elect to deduct the excess in future years, as described in this subrule. See rule 701—40.65(422) for rules applicable to individuals and other noncorporate entities, and see rule 701—53.23(422) for rules applicable to corporations (both C and S corporations) and other entities subject to the corporate income tax.

(1) This special election applies only to section 179 deductions passed through to the financial institution by one or more other entities.

(2) If the total Iowa section 179 deduction passed through to the financial institution exceeds the federal section 179 deduction limitation for that year, the financial institution may only use the amount up to the federal limitation when calculating the deduction under this election. Any amount in excess of the federal limitation shall not be deducted for Iowa purposes.

c. Section 179 assets of a financial institution. A financial institution that makes this special election may not claim an Iowa section 179 deduction for any assets the financial institution placed in service during the same year but must instead depreciate such assets using the modified accelerated cost recovery system (MACRS) without regard to bonus depreciation under Section 168(k) of the Internal Revenue Code. To the extent the financial institution claimed a federal section 179 deduction on those assets, the Iowa depreciation deductions and any basis adjustments resulting from the difference in timing of the recovery between Iowa law and federal law are calculated and tracked on forms made available on the department's website.

EXAMPLE: Bank A, a financial institution doing business in Iowa, places in service \$20,000 worth of section 179 assets in tax year 2019 and claims the deduction for the full amount for federal purposes. Bank A is also a member of B, LLC, an entity that has elected to be taxed as a partnership for federal purposes and does not do any business in Iowa. B, LLC also places section 179 assets in service, properly claims a federal section 179 deduction, and passes a total of \$150,000 of that deduction through to Bank A. For federal purposes, Bank A has a total of \$170,000 in section 179 deductions. Because Bank A has section 179 deductions from a pass-through that exceed the Iowa limitation for 2019, Bank A is eligible for the special election. Bank A makes the special election and claims the maximum Iowa section 179 deduction of \$100,000 on the amount passed through from B, LLC. Under the special election, Bank A will be allowed to deduct the remaining \$50,000 passed through from B, LLC over the next five years, as described in paragraph 59.24(3)“e.” However, because Bank A made the special election, Bank A will be required to depreciate the entire \$20,000 cost of the assets Bank A placed in service in 2019.

d. Calculating the special election. A financial institution that elects to take advantage of the special election must first add together all section 179 deductions which the financial institution received from all relevant pass-through entities. The financial institution must claim an aggregate Iowa section 179 deduction equal to the Iowa limit for the tax year. This amount must be subtracted from the total. Whatever remains is the amount the financial institution will be permitted to deduct (special election deduction) in future years.

e. Special election deduction.

(1) Calculation. This remaining amount from paragraph 59.24(3)“d” must be separated into five equal shares.

(2) Claiming the special election deduction. The financial institution may deduct one of the five shares in each of the next five years. The dollar limitations and reduction limitations on section 179 deductions do not apply to special deduction amounts allowed over the five-year period under this paragraph.

(3) Excess special deduction. The special election deduction for a given year is limited to the taxpayer's business income for that year. Any excess may be carried forward to future years. Any

amounts carried forward under this subparagraph shall be added to, and treated in the same manner as, regular Iowa section 179 deduction carryforwards as described in paragraph 59.24(2) “g.”

EXAMPLE: Bank D, a financial institution doing business in Iowa, is a partner in a partnership that does not do business in Iowa. In 2019, the partnership passes through a \$600,000 federal section 179 deduction and does not recalculate the deduction for Iowa purposes because the partnership has no obligation to file an Iowa return. Bank D claims an Iowa section 179 deduction of \$100,000 (the 2019 Iowa limitation) and elects the five-year carryforward for the rest, meaning the bank will be allowed to take a \$100,000 Iowa special election deduction in each of the next five years.

In 2020, Bank D is eligible for the \$100,000 deduction carried forward under the election, but the bank only has \$50,000 in business income. The deduction is limited to business income, so the bank can only use \$50,000 of the deduction in 2020. However, Bank D will be permitted to treat the excess \$50,000 as a section 179 carryforward and use it to offset business income in future years until the deduction is used up.

f. Basis. The financial institution’s basis in the pass-through entity assets is adjusted by the full amount of the section 179 deduction passed through in the year that the section 179 deduction is received and is therefore the same for both Iowa and federal purposes.

g. Later tax years. For tax years beginning on or after January 1, 2020, Iowa fully conforms to the federal section 179 deduction and special Iowa treatment for excess section 179 deductions received from pass-throughs is not available.

This rule is intended to implement Iowa Code section 422.35 as amended by 2019 Iowa Acts, Senate File 220.

[ARC 9103B, IAB 9/22/10, effective 10/27/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 1101C, IAB 10/16/13, effective 11/20/13; ARC 4142C, IAB 11/21/18, effective 12/26/18; ARC 4517C, IAB 6/19/19, effective 7/24/19]

ALLOCATION AND APPORTIONMENT

701—59.25(422) Basis of franchise tax. Iowa Code section 422.60 imposes a franchise tax on financial institutions (as defined in 701—subrule 57.1(2)) for the privilege of doing business within the state. The tax is measured by net income. For financial institutions subject to the tax, the tax is levied and collected only on income which may accrue or be recognized to the financial institutions from business done or carried on in the state plus net income from certain sources without the state which by rule follows the commercial domicile of the financial institution.

If a financial institution carries on business entirely within the state of Iowa, no allocation or apportionment of its income may be made. The financial institution will be presumed to be carrying on its business entirely within the state of Iowa if its activities are carried on only within Iowa, even though it receives income from sources outside the state in the form of interest, dividends, royalties, and other sources of income from intangibles.

59.25(1) Definition—doing business. The term “doing business” is used in a comprehensive sense and includes all activities or any transactions for the purpose of financial or pecuniary gain or profit. Irrespective of the nature of its activities, every financial institution organized for profit and carrying out any of the purposes of its organization shall be deemed to be “doing business.” In determining whether a financial institution is doing business, it is immaterial whether its activities actually result in a profit or loss.

59.25(2) Definition—carrying on business partly within and partly without the state. “Carrying on business partly within and partly without the state” means having business activities in at least one other state sufficient to meet the minimum constitutional standards for doing business in a state under the due process and commerce clauses of the United States Constitution. The determination of whether a financial institution is carrying on business partly within and partly without the state must be made on a tax-year-by-tax-year basis. The activities of past or future years have no bearing on the current year.

The following nonexclusive activities if done on a regular and continuing basis by financial institution officers or employees in at least one other state would constitute the minimum activities which would meet the constitutional standards for doing business in a state under the due process and commerce clauses of the United States Constitution:

- a. Solicitation of loans by traveling loan officers.
- b. Collection of overdue accounts.
- c. Any other activities carried on in advancement, promotion, or fulfillment of the business of the financial institution.

This rule is intended to implement Iowa Code sections 422.60 and 422.63.

701—59.26(422) Allocation and apportionment.

59.26(1) The classification of income by the labels customarily given, such as interest, dividends, rents, and royalties, is of no aid in determining whether that income is business or nonbusiness income. Interest, dividends, rents and royalties shall be apportioned as business income to the extent the income was earned as a part of a financial institution's unitary business, a portion of which is conducted in Iowa. *Mobil Oil Corp. v. Commissioner of Taxes*, 455 U.S. 425 (1980); *ASARCO, Inc. v. Idaho State Tax Commission*, 458 U.S. 307, 73 L.Ed.2d 787, 102 S.Ct. 3103 (1982); *F. W. Woolworth Co. v. Taxation and Revenue Dept.*, 458 U.S. 354, 73 L.Ed.2d 819, 102 S.Ct. 3128 (1982); *Container Corporation of America v. Franchise Tax Board*, 463 U.S. 159, 77 L.Ed.2d 545, 103 S.Ct. 2933 (1983). Whether income is part of a financial institution's unitary business income depends upon the facts and circumstances in the particular situation. The burden of proof is upon the taxpayer to show that the treatment of income on the return as filed is proper. There is a rebuttable presumption that an affiliated group of financial institutions in the same line of business have a unitary relationship, although that is not the only element used in determining unitariness.

59.26(2) Application of related expense to nonbusiness income. Subrule 59.26(1) deals with the separation of "net" income, therefore, determination and application of related expenses must be made, as hereinafter directed, before allocation and apportionment within and without Iowa. Related expenses shall mean those expenses directly related.

A directly related expense shall mean an expense which can be specifically attributed to an item of income. Interest expense shall be considered directly related to a specific property which generates, has generated, or could reasonably have been expected to generate gross income if the existence of all of the facts and circumstances described below is established. Such facts and circumstances are as follows:

- a. The indebtedness on which the interest was paid was specifically incurred for the purpose of purchasing, maintaining, or improving the specific property;
- b. The proceeds of the borrowing were actually applied to the specified purpose;
- c. The creditor can look only to the specific property (or any lease or other interest therein) as security for the loan;
- d. It may be reasonably assumed that the return on or from the property will be sufficient to fulfill the terms and conditions of the loan agreement with respect to the amount and timing of payment of principal and interest; and
- e. There are restrictions in the loan agreement on the disposal or use of the property consistent with the assumptions described in "c" and "d" above.

A deduction for interest may not be considered definitely related solely to specific property, even though the above facts and circumstances are present in form, if any of the facts and circumstances are not present in substance. Any expense directly attributable to allocable interest, dividends, rents and royalties shall be deducted from income to arrive at net allocable income.

EXAMPLE: For purposes of this example, it is assumed that the taxpayer has nonbusiness rental income. The taxpayer invests in a 20-story office building. Under the terms of the lease agreements, the taxpayer provides heat, electricity, janitorial services, and maintenance. The taxpayer also pays the property taxes. Construction of the building was funded through borrowings which meet the criteria of a direct expense under the provisions of this paragraph. The directly related expenses to the operation of the property are:

Interest expense	\$1,200,000
Property taxes	500,000
Depreciation	500,000
Electricity	300,000
Heat	200,000
Insurance	150,000
Janitorial services	100,000
Repairs	50,000
Total expenses	<u>\$3,000,000</u>

The directly related expense of the allocable rental income is \$3,000,000.

This rule is intended to implement Iowa Code section 422.63.

701—59.27(422) Net gains and losses from the sale of assets. For purposes of administration of this rule, a capital gain or loss shall mean the sale price or value at the time of disposal of an asset less the adjusted basis, whether reportable as short-term or long-term capital gain or ordinary income for federal income tax purposes.

59.27(1) Gain or loss from the sale, exchange, or other disposition of real or tangible or intangible personal property, if the property while owned by the taxpayer was used in the taxpayer's trade or business, shall be apportioned by the business activity ratio applicable to the year the gain or loss is reported on the federal income tax return and may at the taxpayer's election be included in the computation of the business activity ratio as follows:

a. Gain from the sale, exchange, or other disposition of real property shall be included in the numerator if the property is located in this state.

b. Gain from the sale, exchange, or other disposition of tangible personal property shall be included in the numerator if:

(1) The property has a situs in this state at the time of sale; or

(2) The taxpayer's commercial domicile is in this state and the taxpayer is not taxable in the state in which the property had a situs.

c. Gains from the sale, exchange, or other disposition of intangible personal property shall be included in the numerator if the taxpayer's commercial domicile is in this state.

d. All gains shall be included in the denominator of the activity ratio.

A taxpayer cannot elect to exclude or include gains or loss from the sale of assets where the election would result in an understatement of income reasonably attributable to Iowa. Noninclusive examples of gains or loss from the sale, exchange or other disposition of real or tangible or intangible property which may not be included in the computation of the business activity ratio because to do so would result in an understatement of net income reasonably attributable to Iowa are the gain recognized under an election pursuant to Section 338 of the Internal Revenue Code or gain recognized under Section 631(a) of the Internal Revenue Code.

59.27(2) Gain or loss from the sale, exchange, or other disposition of property not used in the taxpayer's trade or business shall be allocated as follows:

a. Gains or losses from the sale, exchange, or other disposition of real property located in this state are allocable to this state.

b. Gains or losses from the sale, exchange, or other disposition of tangible personal property are allocable to this state if:

(1) The property has a situs in this state at the time of sale; or

(2) The taxpayer's commercial domicile is in this state and the taxpayer is not taxable in the state in which the property had a situs.

c. Gains or losses from the sale, exchange, or other disposition of intangible personal property are allocable to this state if the taxpayer's commercial domicile is in this state.

This rule is intended to implement Iowa Code section 422.63.

701—59.28(422) Apportionment factor. In determining the total net taxable income, the apportionable income attributable to this state, as determined by use of the apportionment fraction, shall be added to the nonapportionable income allocable to this state.

59.28(1) Receipts derived from transactions and activities in the regular course of trade or business which produce business income are included in the denominator of the apportionment factor. Income which is not subject to the Iowa franchise tax shall not be included in the computation of the apportionment factor.

59.28(2) The numerator of the apportionment factor is that portion of the total receipts included in the denominator of the taxpayer attributable to this state during the income year determined as follows:

a. Receipts from the lease, rental, or other use of real property shall be included in the numerator if the real property is located in Iowa.

b. Receipts from the sale of tangible personal property shall be included in the numerator if the property is delivered or shipped to a purchaser in this state regardless of the f.o.b. point or other conditions of the sales.

c. Receipts from the use of tangible personal property shall be included in the numerator of the business activity formula to the extent that property is utilized in Iowa. The extent of utilization of tangible personal property in a state is determined by multiplying the rent by a fraction, the numerator of which is the number of days of physical location of the property in the state during the rental period in the taxable year and the denominator of which is the number of days of physical location of the property everywhere during all rental periods in the taxable year. If the physical location of the property during the rental period is unknown or not ascertainable by the taxpayer, tangible personal property is utilized in the state in which the property was located at the time the rental payer obtained possession.

d. All royalty income from intangible personal property determined to be business income shall be included in the numerator of the business activity formula if the taxpayer's commercial domicile is in Iowa. All royalty income from tangible personal property or real property determined to be business income shall be included in the numerator of the business activity formula if the situs of the tangible personal property or real property is within Iowa.

e. Interest and other receipts from assets in the nature of loans (including federal funds sold and banker's acceptances) and installment obligations shall be attributed to the state where the borrower is located.

f. Interest income from a participating bank's portion of participation loan shall be attributed to the state where the borrower is located.

g. Interest income from loans solicited by traveling loan officers shall be attributed to the state where the borrower is located.

h. Interest or service charges from bank, travel, and entertainment credit card receivables and credit card holders' fees shall be attributed to the state in which the credit card holder resides in the case of an individual or, if a corporation, to the state of the corporation's commercial domicile.

i. Merchant discount income derived from bank and financial corporation credit card holder transactions with a merchant shall be attributed to the state in which the merchant is located. It shall be presumed that the location of the merchant is the address on the invoice submitted by the merchant to the taxpayer.

j. Receipts for the performance of fiduciary services are attributable to the state where the services are principally performed.

k. Receipts from investments of a bank in securities, the income from which constitutes business income, shall be attributed to its commercial domicile except that:

(1) Receipts from securities used to maintain reserves against deposits to meet federal and state reserve deposit requirements shall be attributed to each state based upon the ratio that total deposits in the state bear to total deposits everywhere.

(2) Receipts from securities owned by a bank but held by a state treasurer or other public official or pledged to secure public or trust funds deposited in the bank shall be attributed to the banking office at which the secured deposit is maintained.

l. Receipts (fees or charges) from the issuance of traveler's checks and money orders shall be attributed to the state where the taxpayer's office is located that issued the traveler's checks. If the traveler's checks are issued by an independent representative or agent of the taxpayer, the fees or charges shall be attributed to the state where the independent representative or agent issued the traveler's checks.

m. Fees, commissions, or other compensation for financial services rendered for a customer located in this state or an account maintained within this state.

n. Any other gross receipts resulting from the operation as a financial organization within the state to the extent the items do not represent a recapture of an expense.

o. Receipts from management services if the recipient of the management services is located in this state.

This rule is intended to implement Iowa Code section 422.63.
[ARC 4955C, IAB 2/26/20, effective 4/1/20; see Rescission note at end of chapter]

701—59.29(422) Allocation and apportionment of income in special cases. If a taxpayer feels that the allocation and apportionment method as prescribed by rule 701—59.28(422) in the taxpayer's case results in an injustice, the taxpayer may petition the department for permission to determine the taxable net income, both allocable and apportionable, to the state on some other basis.

The taxpayer must first file the return as prescribed by rule 701—59.28(422) and pay the tax shown due thereon. If a change to some other method is desired, a statement of objections and schedules detailing the alternative method shall be submitted to the department. The department shall require detail and proof within the time as the department may reasonably prescribe. In addition, the alternative method of allocation and apportionment will not be allowed where the taxpayer fails to produce, upon request of the department, any information the department deems necessary to analyze the request for an alternative method of allocation and apportionment. The petition must be in writing and shall set forth in detail the facts upon which the petition is based. The burden of proof will be on the taxpayer as to the validity of the method and its results. The mere fact that an alternative method of apportionment or allocation produces a lesser amount of income attributable to Iowa is, per se, insufficient proof that the statutory method of allocation and apportionment is invalid. *Moorman Manufacturing Company v. Bair*, 437 U.S. 267, 57 L.Ed.2d 197 (1978). In essence, a comparison of the statutory method of apportionment with another formulary apportionment method is insufficient to prove that the taxpayer would be entitled to the alternative formulary apportionment method. *Moorman Manufacturing Company v. Bair*, supra.

One of the possible alternative methods of allocation and apportionment is separate accounting provided the taxpayer's activities in Iowa are not unitary with the taxpayer's activities outside Iowa. Any corporation deriving income from business operations partly within and partly without Iowa must determine that net business income attributable to this state by the prescribed formula for apportioning net income, unless the taxpayer proved by clear and cogent evidence that the statutory formula apportions income to Iowa out of all reasonable proportion to the business transacted within Iowa. *Moorman Manufacturing Company v. Bair*, supra.

Separate accounting is not allowable for a unitary business where the separate accounting method fails to consider factors of profitability resulting from functional integration, centralization of management, and economics of scale. *Shell Oil Company v. Iowa Department of Revenue*, 414 N.W.2d 113 (Iowa 1987).

The burden of proof that the statutory method of apportionment attributes to Iowa income out of all reasonable proportion to the business transacted within Iowa is on the taxpayer. In order to utilize separate accounting, the taxpayer's books and records must be kept in a manner that accurately depicts the exact geographical source of profits. In any petition to utilize separate accounting, the taxpayer must submit schedules which accurately depict net income by division or product line and the amount of income earned within Iowa.

There are alternative methods of separate accounting utilizing different accounting principles. A mere showing that one separate accounting method produces a result substantially different than the statutory method of apportionment is not sufficient to justify the granting of the separate accounting method shown. The taxpayer must not only show that the separate accounting method advocated by the taxpayer in comparison with the statutory method of apportionment produces a result which, if the statutory method of apportionment were used, would be out of all reasonable proportion to the business transacted within Iowa. The taxpayer must also show that all other conceivable reasonable separate accounting methods would show, when compared with the statutory method of apportionment, that the statutory method of apportionment substantially produces a distorted result.

As used in this rule, “statutory method of apportionment” means the apportionment factor set forth in rule 701—59.28(422).

All requests to use an alternative method of allocation and apportionment submitted to the department will be considered by the compliance division if the request is the result of an audit or by the taxpayer services and policy division if the request is received prior to audit. If the department concludes that the statutory method of allocation and apportionment is, in fact, both inapplicable and inequitable, the department shall prescribe a special method. The special method of allocation and apportionment prescribed by the department may be that requested by the taxpayer or some other method of allocation and apportionment which the department deems to equitably attribute income to business activities carried on within Iowa.

If the taxpayer disagrees with the determination of the department, the taxpayer may file a protest within 60 days of the date of the letter setting forth the department’s determination and the reasons therefor in accordance with rule 701—7.8(17A). The department’s determination letter shall set forth the taxpayer’s rights to protest the department’s determination.

If no protest is filed within the 60-day period, then no hearing will be granted on the department’s determination under this rule. However, this does not preclude the taxpayer from subsequently raising this question in the event that the taxpayer protests an assessment or denial of a timely refund claim, but this issue will only be dealt with for the years involved in the assessment or timely refund claim.

The use of an alternative method of allocation and apportionment would only be applicable to the years under consideration at the time the special method of allocation and apportionment is prescribed. The taxpayer’s continued use of a prescribed method of allocation and apportionment will be subject to review and change within the statutory, or legally extended period(s).

If there is a material change in the business operations or accounting procedures from those in existence at the time the taxpayer was permitted to determine the net income earned within Iowa by an alternative method of allocation and apportionment, the taxpayer shall apprise the department of such changes prior to filing the taxpayer’s return for the current year. After reviewing the information submitted, along with any other information the department deems necessary, the department will notify the taxpayer if the alternative method of allocation and apportionment is deemed applicable.

This rule is intended to implement Iowa Code section 422.63.

[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—59.30(422) Broadband infrastructure grant exemption.

59.30(1) *Broadband infrastructure grant exemption, generally.* For tax years beginning on or after January 1, 2019, certain qualifying communications service providers may subtract, to the extent included in income, the amount of qualifying government grants used to install broadband infrastructure that facilitates broadband service in targeted service areas at or above download and upload speeds identified by the Federal Communications Commission pursuant to Section 706 of the federal Telecommunications Act of 1996, as amended. This rule explains terms not defined in Iowa Code section 422.35.

59.30(2) *Definitions.*

“*Facilitate*” shall have the same meaning as defined in Iowa Code section 8B.1.

“*Grant*” means a transfer for a governmental purpose of money or property to a transferee that is not a related party to or an agent of the transferor. The transfer must not impose any obligation or condition

to directly or indirectly repay any amount to the transferor or a related party. Obligations or conditions intended solely to assure expenditure of the transferred moneys in accordance with the governmental purpose of the transfer do not prevent a transfer from being a grant.

1. “Federal grant” means any grant issued by the United States government, including any agency or instrumentality thereof.

2. “State grant” means any grant issued by any state of the United States, the District of Columbia, or a territory or possession of the United States, including any agency or instrumentality thereof.

3. “Local grant” means any grant issued by any city, county, township, school district, or any other unit of local government, including any agency or instrumentality thereof.

59.30(3) *Limitation on certain refund claims.* For tax years beginning on or after January 1, 2019, and before January 1, 2020, refund claims resulting from this exemption must be filed prior to October 1, 2020. No refunds shall be issued for claims filed on or after that date.

This rule is intended to implement Iowa Code section 422.35.

[ARC 5606C, IAB 5/5/21, effective 6/9/21]

Rules 701—59.25(422) to 701—59.29(422) are effective for tax years beginning on or after June 1, 1989.

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[Rescinded paragraph editorially removed, IAC Supplement 7/29/20]¹
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IAB 5/5/21, effective 6/9/21]

⁰ Two or more ARCs

¹ Paragraph 59.28(2)“p” rescinded by 2020 Iowa Acts, House File 2641, section 79, effective June 29, 2020.

CHAPTER 216
BUNDLED TRANSACTIONS

701—216.1(423) Taxability of bundled transactions. The sales price of a bundled transaction is subject to tax if any product included in the bundled transaction would be taxable if sold separately. For purposes of this rule, products include tangible personal property, services, and specified digital products and exclude real property and services to real property.

[ARC 5605C, IAB 5/5/21, effective 6/9/21]

701—216.2(423) Bundled transaction. A “bundled transaction” is the retail sale of two or more products where the products are otherwise distinct and identifiable and the products are sold for one nonitemized price.

216.2(1) *Distinct and identifiable product.* “Distinct and identifiable product” does not include any of the following:

a. Packaging or other materials that accompany the retail sale of the products and are incidental or immaterial to the retail sales of the products. Packaging or other materials include, but are not limited to, containers, boxes, sacks, bags, bottles, envelopes, wrapping, labels, tags, twine, garment hangers, and instruction guides.

EXAMPLE 1: Seller Z provides paper and plastic bags for purchasers to use to carry away their purchased items. The bags are incidental or immaterial to the retail sales of the products and are not distinct and identifiable products. Seller Z’s retail sale of purchased items in the provided bags does not constitute a bundled transaction.

EXAMPLE 2: Seller X sells brownies and offers purchasers the option of adding a premium box for an increased price. The sales price of the brownies is the same whether they are sold on their own or with a standard box, but the total sales price increases if the purchasers select a premium box. The premium box is distinct and identifiable from the food product because it requires separate shopping preferences and product selection by the purchaser and is not standard with every order of food product. The retail sale of the brownies and the premium box may constitute a bundled transaction if the other requirements pursuant to Iowa Code section 423.2(8) are satisfied.

EXAMPLE 3: Seller A offers purchasers the option to buy reusable, long-lasting grocery bags to use to carry away purchased grocery items. If the reusable grocery bags are purchased with other items and separately itemized, they are taxable and the sale does not constitute a bundled transaction.

b. A product that is provided free of charge to the consumer in conjunction with the required purchase of another product, if the sales price of the other product does not vary depending on whether the product provided free of charge is included in the transaction. Examples include a free car wash with the purchase of gasoline or free dinnerware with the purchase of groceries.

c. Items specified in the definition of “sales price” in Iowa Code section 423.1.

216.2(2) *One nonitemized price.* “One nonitemized price” does not include the following:

a. A price that is separately identified by product on a binding sales document, or other sales-related documentation, that is made available to the customer in paper or electronic form, including but not limited to an invoice, a bill of sale, a receipt, a contract, a service agreement, a lease agreement, a periodic notice of rates and services, a rate card or a price list.

b. A price for which the sales price varies or is negotiable based on the purchaser’s selection of the products included in the transaction even if the seller only provides one price on its invoice to the purchaser.

EXAMPLE 1: Seller A sells a bakery item as part of a meal which consists of taxable prepared food. The purchaser selects items from a list of options of prepared food to be included in the meal. The individual items of the meal are not itemized on the receipt and the meal is always the same price, notwithstanding the items selected by the purchaser. The meal is sold for one nonitemized price, and the sales price of the meal is subject to tax as a bundled transaction.

EXAMPLE 2: Seller B enters into a contract with buyer D to provide various information technology services. Buyer D selects the information technology services it wants from seller B. Through

negotiation, buyer D and seller B agree on a price based on the services selected and seller B bills buyer D one price for all of the services, some of which are taxable and some of which are not taxable. Although the invoice from seller B to buyer D only contains one price for all of the services, since the price was based on the products selected by buyer D, the price is not one nonitemized price and the sale does not constitute a bundled transaction.

[ARC 5605C, IAB 5/5/21, effective 6/9/21]

701—216.3(423) Transactions not taxable as bundled transactions. Generally, the entire sales price from a bundled transaction is subject to sales tax. However, the transactions described in this rule are not taxable as bundled transactions:

216.3(1) Sales involving mixed tangible personal property and services. The retail sale of tangible personal property or specified digital product and a service, if the tangible personal property or specified digital product is essential to the use of the service, and provided exclusively in connection with the service, and if the true object of the transaction is the service.

EXAMPLE: Seller A charges customer B for computer programming services where customer B is also given a backup disk and instruction manual. The true object of the transaction is the provision of the programming services. Seller A is selling nontaxable services and is not making a sale of a bundled transaction. Iowa sales tax is not due on the programmer's charge for services; sales tax is due on seller A's purchases of tangible personal property used to fulfill the service.

216.3(2) Sales involving services. The retail sale of services, if one of the services is essential to the use or receipt of a second service, and provided exclusively in connection with the second service, and if the true object of the transaction is the second service. If the transaction is not a bundled transaction as a result of this exclusion, then the true object of the transaction will be the retail sale of the second service and should be taxed accordingly.

216.3(3) True object test. The true object of a transaction is the main product that is the subject of the transaction. Determining the true object of a transaction is a fact-based inquiry and shall be made on a case-by-case basis. Factors that may be considered in determining the true object of a transaction include, but are not limited to, the nature of the seller's business and purchaser's reason for making the purchase.

216.3(4) Sales involving "de minimis" taxable products. A transaction that includes taxable and nontaxable products and the seller's purchase price or sales price of the taxable products is de minimis. "De minimis" means the seller's purchase price or sales price of the taxable products is 10 percent or less of the total purchase price or sales price of the bundled products. A seller shall use either the seller's purchase price or seller's sales price of the products to determine if the taxable products are de minimis. A seller may not use a combination of the seller's purchase price and seller's sales price of the products to determine if the taxable products are de minimis.

EXAMPLE 1: Seller H sells a coupon book that includes a packet of stickers for one nonitemized price of \$75. The packet of stickers is not provided free of charge. Seller H purchased the stickers, a taxable product, for \$2 per packet, which does not exceed 10 percent of the total purchase price of the coupon book and stickers. Seller H's sale of the coupon book and stickers is not a bundled transaction, and the sales price of \$75 is not subject to tax.

EXAMPLE 2: Technology Company F (company F) sells access to a day-long live webinar about the latest trends occurring in the technology industry for one nonitemized price of \$200. The webinar, which does not allow people viewing the presentation to submit questions, is not subject to Iowa sales tax. The customer also receives a smartwatch that is included in the payment of the webinar but is not provided free of charge. Company F's sales price of the smartwatch is \$50, which exceeds 10 percent of the total sales price of the fee. The watch is subject to sales tax by the customer. Because company F's purchase price of the watch is not de minimis, the \$200 transaction is a bundled transaction and is subject to tax.

216.3(5) Sales involving taxable and exempt food or medical products. The retail sale of exempt tangible personal property and taxable tangible personal property where all of the following apply:

a. The transaction includes food and food ingredients, drugs, durable medical equipment, mobility enhancing equipment, prosthetic devices, or medical supplies; and

b. The seller's purchase price or sales price of the taxable tangible personal property is 50 percent or less of the total purchase price or sales price of the bundled tangible personal property. Sellers may not use a combination of the purchase price and sales price of the tangible personal property when making the 50 percent determination for a transaction.

EXAMPLE: Seller F offers its customers a package containing two prepared hot dogs and five frozen hot dogs. The sales price for the two prepared hot dogs is \$5, and the sales price of the five frozen hot dogs is \$10. The package is sold for one nonitemized price of \$15. The sales price of the package is not taxable because the sales price of the taxable items (the two prepared hot dogs) is 50 percent or less of the total sales price of the package.

[ARC 5605C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code section 423.2(8).

[Filed ARC 5605C (Notice ARC 5504C, IAB 3/10/21), IAB 5/5/21, effective 6/9/21]

CHAPTERS 217 and 218
Reserved

CHAPTER 231
EXEMPTIONS PRIMARILY OF BENEFIT TO CONSUMERS

Rules in this chapter include cross references to provisions in 701—Chapters 15 to 20, 21, 26, 30, 32 and 33 that were applicable prior to July 1, 2004.

701—231.1(423) Newspapers, free newspapers and shoppers' guides.

231.1(1) *In general.* The sales price from the sales of newspapers, free newspapers, and shoppers' guides is exempt from tax. The sales price from the sales of magazines, newsletters, and other periodicals which are not newspapers is taxable. Cases decided by the United States Supreme Court and the Supreme Court of Iowa prohibit exempting from taxation the sale of any periodical if that exemption from taxation is based solely upon the contents of that periodical. See *Arkansas Writers' Project, Inc. v. Ragland*, 481 U.S. 221, 107 S.Ct. 1722, 95 L.Ed.2d 209 (1987) and *Hearst v. Iowa Department of Revenue & Finance*, 461 N.W.2d 295 (Iowa 1990).

231.1(2) *General characteristics of a newspaper.* "Newspaper" is a term with a common definition. A "newspaper" is a periodical, published at short, stated, and regular intervals, usually daily or weekly. It is printed on newsprint with news ink. The format of a newspaper is that of sheets folded loosely together without stapling. A newspaper is admitted to the U.S. mails as second-class material. Other frequent characteristics of newspapers are the following:

- a. Newspapers usually contain photographs.
- b. Information printed on newspapers is usually contained in columns on the newspaper pages.
- c. The larger the cross section of the population which reads a periodical in the area where the periodical circulates, the more likely it is that the department will consider that periodical to be a "newspaper."

231.1(3) *Characteristics of newspaper publishing companies.* Often, companies publishing larger newspapers will subscribe to various syndicates or wire services. A larger newspaper will employ a general editor and a number of subordinate editors as well, for example, sports and lifestyle editors; business, local, agricultural, national, and world news editors; and editorial page editors. A larger newspaper will also employ a variety of reporters and staff writers. Smaller newspapers may or may not have these characteristics or may consolidate these functions.

231.1(4) *Characteristics which distinguish a newsletter from a newspaper.* A "newsletter" is generally distributed to members or employees of a single organization and not usually to a large cross section of the general public. It is often published at irregular intervals by a volunteer, rather than by a paid individual who usually publishes a newspaper. A newsletter is often printed on sheets which are held together at one point only by a staple, rather than folded together.

This rule is intended to implement 2005 Iowa Code subsection 423.3(54).

701—231.2(423) Motor fuel, special fuel, aviation fuels and gasoline.

231.2(1) *In general.* The sales price from the sale of motor fuel, including ethanol, and special fuel is exempt from sales tax under 2005 Iowa Code section 423.3(55) if (a) the fuel is consumed for highway use, in watercraft, or in aircraft, (b) the Iowa fuel tax has been imposed and paid, and (c) no refund or credit of fuel tax has been made or will be allowed. The sales price from the sale of special fuel for diesel engines used in commercial watercraft on rivers bordering Iowa is exempt from sales tax, even though no fuel tax has been imposed and paid, providing the seller delivers the fuel to the owner's watercraft while it is afloat.

231.2(2) *Refunds or credits of motor fuel and special fuel.* Claims for refund or credit of fuel taxes under the provisions of Iowa Code chapter 452A must be reduced by any sales or use tax owing the state unless a sales tax exemption is applicable. Generally, refund claims or credits are allowed where fuel is purchased tax-paid and used for purposes other than to propel a motor vehicle or used in watercraft.

231.2(3) *Refunds of tax on fuel purchased in Iowa and consumed outside of Iowa.* Even though fuel is purchased in Iowa, fuel tax is paid in Iowa, and the fuel tax is subject to refund under the provisions of division III of Iowa Code chapter 452A relating to interstate motor vehicle operations, the refund of

the fuel tax does not subject the purchase of the fuel to sales tax. Subjecting the purchase of the fuel to sales tax has the effect of imposing sales tax when fuel is consumed in interstate commerce while fuel consumed on Iowa highways in intrastate commerce is exempt from sales tax pursuant to 2005 Iowa Code subsection 423.3(55). The effect for sales tax purposes is to impose a greater tax burden on non-Iowa highway fuel consumption than Iowa highway fuel consumption, thereby discriminating against interstate commerce. In addition, the effect of imposing sales tax on interstate excess purchases where intrastate highway use is not subject to the tax constitutes an export duty for purchasing fuel in Iowa and exporting it for use in another state. Such effects are in violation of the commerce clause of the United States Constitution. *Boston Stock Exchange v. State Tax Commission*, 1977, 429 U.S. 319, 97 S.Ct. 599, 50 L.Ed.2d 514 and *Coe v. Errol*, 1886, 116 U.S. 517, 6 S.Ct. 475, 29 L.Ed. 715.

231.2(4) Tax base. The basis for computing the Iowa sales tax will be the retail sales price of the fuel less any Iowa fuel tax included in such price. Federal excise tax should not be removed from the sales price in determining the proper sales tax due. *W. M. Gurley v. Army Rhoden* supra. Also reference rule 701—15.12(422,423).

This rule is intended to implement Iowa Code subsection 423.3(55).

701—231.3(423) Sales of food and food ingredients. On and after July 1, 2004, the sales price from all sales of food and food ingredients is exempt from tax. For the purposes of this rule, “food and food ingredients” means substances, whether in liquid, concentrated, solid, frozen, dried, or dehydrated form, that are sold for ingestion or chewing by humans and are consumed for their taste or nutritional value.

231.3(1) Most substances can easily be classified either as food, food ingredients, or nonfood items. There are, however, certain substances that are not readily distinguishable as food or nonfood and may present problems in judgment. The following guidelines apply to some of the more unique categories of eligible foods and food ingredients and ineligible nonfood items about which questions may arise. The guidelines and their lists are not to be considered all-inclusive:

a. Foods eligible for purchase with food coupons. Sales of almost all substances which may be purchased with food coupons issued by the United States Department of Agriculture under the regulations in effect on July 1, 1974, remain exempt from tax on and after July 1, 2004. However, since the exemption no longer depends on ability to be purchased with food stamps (reference 701—subrule 20.1(1)), sales of certain substances which can be purchased with food stamps but are neither food nor food ingredients are taxable on and after July 1, 2004.

These taxable sales include garden seeds and plants sold for use in gardens to produce food for human consumption. Seeds and plants eligible for purchase with food coupons include vegetable seeds and food-producing plants such as tomato and green pepper plants and fruit trees, food-producing roots, bushes, and bulbs (e.g., asparagus roots and onion sets) and seeds and plants used to produce spices for use in cooking foods. Sales of all these substances are taxable. Sales of chewing gum are taxable as sales of “candy” on and after July 1, 2004.

b. Distilled water and ice. These substances, although having some nonfood uses, are largely used as food or as ingredients in food for human consumption. Unless these substances are specifically labeled for nonfood use or the recipient indicates that they will be used for some purpose other than as food for human consumption or as ingredients in food for human consumption, their sales are exempt from tax.

c. Specialty foods. This category of eligible foods includes special dietary foods (e.g., diabetic and dietetic), enriched or fortified foods, infant formulas, and certain foods commonly referred to as health food items. These substances are food products which are substituted for more commonly used food items in the diet, and thus they are purchased for ingestion by humans and are consumed for their taste or nutritional value. Examples of items in this category of eligible foods are Metrecal, Enfamil, Sustegen, wheat germ, brewer’s yeast, sunflower seeds which are packaged for human consumption, and rose hips powder which is used for preparing tea. It is not possible to formulate a comprehensive list of eligible specialty foods. The guideline to be used to determine the eligibility of a specific product is the ordinary use of the product.

NOTE: If the product is primarily used as a food or as an ingredient in food, then it is an eligible item; if it is primarily used for medicinal purposes as either a therapeutic agent or a deficiency corrector and only occasionally used as a food, the product is not an eligible item.

d. Snack foods. These substances are food items and, therefore, are usually eligible for the exemption. Typical examples of snack foods are cheese puffs; corn chips; popcorn; peanuts; potato chips and sticks; packaged cookies, cupcakes, and donuts; and pretzels. Alcoholic beverages, candy, and soft drinks are examples of snack foods the sales of which are not exempt from tax; see subrule 231.3(2).

e. Others. There are certain eligible food substances which are normally consumed only after being incorporated into foods sold for ingestion or chewing by humans. Sales of substances which are ingredients of items identical to those which are eligible for exemption when sold as finished products are sales eligible for exemption. Since these substances are food ingredients, their sales are exempt. An example is pectin. Pectin is the generic term for products marketed under various brand names and commonly used as a base in making jams and jellies. When pectin is incorporated into jams or jellies, it becomes part of a food for human consumption and, therefore, is an eligible food item. Other examples are lard and vegetable oils.

f. The following general classifications of food products are also exempt from tax unless taxable as prepared food; see rule 701—231.5(423):

- Bread and flour products
- Bottled water, unless it is a sweetened bottled water and thus taxable as a soft drink (a change from previous law; reference 701—subparagraph 20.1(3) “b”(1))
- Cereal and cereal products
- Cocoa and cocoa products, unless taxable in the form of candy as in rule 701—231.4(423)
- Coffee and coffee substitutes, unless taxable as soft drinks; see paragraph 231.3(2) “f”
- Dietary substitutes, other than dietary supplements; see paragraphs 231.3(1) “c” and 231.3(2) “a”
- Eggs and egg products
- Fish and fish products
- Frozen foods
- Fruits and fruit products including fruit juices, unless taxable as soft drinks; see paragraph 231.3(2) “f”
- Margarine, butter, and shortening
- Meat and meat products
- Milk and milk products, including packaged ice cream products
- Milk substitutes, such as soy and rice milk substitutes (a change from previous law; reference 701—subparagraph 20.1(3) “b”(2))
- Spices, condiments, extracts, and artificial food coloring
- Sugar and sugar products and substitutes, unless taxable in the form of candy as in rule 701—231.4(423)
- Tea, unless taxable as a soft drink; see paragraph 231.3(2) “f”
- Vegetables and vegetable products

231.3(2) Substances excluded from the term “food and food ingredients.” Sales of alcoholic beverages, candy, dietary supplements, food sold through vending machines, prepared food, soft drinks, and tobacco are not sales of “food” and are not exempt from tax by this rule.

a. “Alcoholic beverages” means beverages that are suitable for human consumption and contain one-half of 1 percent or more of alcohol by volume.

b. “Candy.” See rule 701—231.4(423).

c. “Dietary supplement” means any product, other than tobacco, intended to supplement the diet that contains one or more of the following dietary ingredients:

- (1) A vitamin.
- (2) A mineral.
- (3) An herb or other botanical.
- (4) An amino acid.

(5) A dietary substance for use by humans to supplement the diet by increasing the total dietary intake.

(6) A concentrate, metabolite, constituent, extract, or combination of any of the ingredients in subparagraphs (1) through (5) that is intended for ingestion in tablet, capsule, powder, softgel, gelcap, or liquid form, or if not intended for ingestion in such a form, is not represented as conventional food and is not represented for use as a sole item of a meal or of the diet; and is required to be labeled as a dietary supplement, identifiable by the “supplement facts” box found on the label and as required pursuant to 21 Code of Federal Regulations 101.36.

Dietary supplements, as their name indicates, serve as supplements to food or food products rather than as “food,” and, therefore, are not included within the definition of that word. Since these substances serve as deficiency correctors or therapeutic agents to supplement diets deficient in essential nutrition rather than as foods, they are not eligible for the food and food ingredients exemption. In addition to vitamin and mineral tablets or capsules, this category includes substances such as cod liver oil, which is used primarily as a source of vitamins A and D. It is not possible to provide a comprehensive list of other such items which are primarily used for medicinal purposes or as health aids and which may be stocked by authorized firms.

d. “Food sold through vending machines” means food dispensed from a machine or other mechanical device that accepts payment, other than food which would be qualified for exemption if purchased with coupons (commonly known as “food stamps”) issued under the federal Food Stamp Act of 1977, 7 United States Code 2011 et seq. Alcoholic beverages, candy, dietary supplements, prepared food, soft drinks, and tobacco sold through vending machines are sold subject to tax in all instances because they are specifically excluded from this rule’s definition of “foods”; see subrule 231.3(2) generally. This paragraph “*d*” should be interpreted in such a fashion that if the sale of a substance is exempt from tax because it is a sale of “food” when the substance is sold by means other than a vending machine, then the sale of that same substance through a vending machine will also be exempt from tax. Conversely, if the sale of a substance by any means other than through a vending machine is taxable, then the sale of that same substance through a vending machine will also be taxable.

e. “Prepared food.” See rule 701—231.5(423).

f. “Soft drinks” means nonalcoholic beverages that contain natural or artificial sweeteners. Soft drinks may be noncarbonated. “Soft drinks” does not include beverages that contain milk or milk products; soy, rice, or similar milk substitutes; coffee and tea which are not sweetened; effervescent, noneffervescent, and mineral water sold in containers; beverages that contain greater than 50 percent of vegetable or fruit juice by volume. This latter is a change from the law as it existed prior to July 1, 2004, which required a volume of only 15 percent for exemption.

Taxable soft drinks are noncarbonated water and soda water if naturally or artificially sweetened; soft drinks carbonated and noncarbonated including but not limited to colas, ginger ale, near beer, and root beer; bottled and sweetened tea and coffee; lemonade, orangeade, and all other drinks or punches with natural fruit or vegetable juice less than 50 percent by volume.

Beverage mixes and ingredients intended to be made into soft drinks are taxable. Beverage mixes or ingredients may be liquid or frozen, concentrated or nonconcentrated, dehydrated, powdered, granulated, sweetened or unsweetened, seasoned or unseasoned. Sales of beverage mixes to which a sweetener is to be added before drinking are taxable. Concentrates intended to be made into beverages which contain natural fruit or vegetable juice of less than 50 percent by volume are taxable.

Beverages, the sales of which are otherwise exempt, are taxable if sold as prepared food under rule 701—231.5(423).

Nondairy coffee “creamers” in liquid, frozen or powdered form are not beverages. Sugar or other artificial or natural sweeteners sold separately are not taxable as beverage ingredients. Specialty foods that are liquids or that are to be added to a liquid and that are intended to be a substitute in the diet for more commonly used food items are not beverages and are not taxable as beverages. These foods include infant formula.

g. “Tobacco” means cigarettes, cigars, chewing or pipe tobacco, or any other item that contains tobacco.

231.3(3) Other substances which are not food or food ingredients. Various products are not purchased for ingestion or chewing by humans or, if they are, are not consumed for their taste or nutritional value. Therefore, they are not purchased exempt from tax under this rule. They include, but are not limited to, the following:

a. Health aids. Over-the-counter medicines and other products used primarily as health aids or therapeutic agents are not foods since they are consumed for their medicinal value as opposed to their nutritional value or taste. Such products include aspirin, cough drops or syrups and other cold remedies, antacids, and all over-the-counter medicines or other products used as health aids. In addition to these commonly used health aids, any product used primarily for medicinal purposes is ineligible. An example of such products is slippery elm powder, a demulcent which is used to soothe sore throats.

b. Items not exempt. The following general classifications of products are subject to tax:

Cosmetics

Household supplies

Paper products

Pet foods and supplies

Soaps and detergents

Tobacco products

Toiletry articles

Tonics

Lunch counter foods or foods prepared for consumption on the premises of the retailer

This rule is intended to implement Iowa Code subsection 423.3(56).

701—231.4(423) Sales of candy.

231.4(1) Definitions.

a. Candy. For the purposes of this rule, “candy” is a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts or other ingredients or flavorings in the form of bars, drops, or pieces. “Candy” shall not include any preparation containing flour and shall require no refrigeration. Any preparation to which flour has been added only for the purpose of excluding the candy’s sales from tax and not for any legitimate purpose, culinary or otherwise, shall not be sold exempt from tax under this rule. This definition is intended to be used when a person is trying to determine if a product that is commonly thought of as “candy” is in fact “candy.” For example, the definition would be applied in a situation where a person is trying to determine if a product is “candy” as opposed to a cookie. The definition is not intended to be applied to every type of food product sold. Many products, such as meat products, breakfast cereals, potato chips, and canned fruits and vegetables are not commonly thought of as “candy.” The definition of “candy” is not applicable to products such as these since they are not commonly thought of as candy.

b. Preparation. Candy must be a “preparation” that contains certain ingredients, other than flour. A “preparation” is a product that is made by means of heating, coloring, molding, or otherwise processing any of the ingredients listed in the definition of “candy.” For example, reducing maple syrup into pieces and adding coloring to make maple candy is a form of preparation.

c. Bars, drops or pieces. Candy must be sold in the form of bars, drops, or pieces.

(1) A “bar” is a product that is sold in the form of a square, oblong, or similar form. For example, if Company A sells one-pound square blocks of chocolate, the blocks of chocolate are “bars.”

(2) A “drop” is a product that is sold in a round, oval, pear-shaped, or similar form. For example, if Company B sells chocolate chips in a bag, each individual chocolate chip contains all of the ingredients indicated on the label and the chocolate chips are “drops.”

(3) A “piece” is a portion that has the same makeup as the product as a whole. Individual ingredients and loose mixtures of items that make up the product as a whole are not pieces. EXCEPTION: If a loose mixture of different items that make up the product as a whole are all individually considered candy and are sold as one product, that product is also candy.

EXAMPLE 1: Company C sells jellybeans in a bag. Each jellybean is made up of the ingredients indicated on the label. Each jellybean is a “piece” or “drop.”

EXAMPLE 2: Company D sells trail mix in a bag. The product being sold (trail mix) is made up of a mixture of carob chips, peanuts, raisins, and sunflower seeds. The individual items that make up the trail mix are not “pieces,” but instead are the ingredients, which, when combined, make up the trail mix. Therefore, the trail mix is not sold in the form of bars, drops, or pieces.

EXAMPLE 3: Company E sells a product called “candy lovers mix.” Candy lovers mix is a product that is made up of a loose mixture of jellybeans, toffee, and caramels. Individually, the jellybeans, toffee, and caramels are all candy. The sale of the mixture is the sale of candy since all of the individual items that make up the product are individually considered to be candy.

EXAMPLE 4: Company F sells cotton candy which is packaged and sold in grocery stores. Cotton candy contains sugar, corn syrup, water, coloring, and flavoring; it does not contain flour. Cotton candy is not “candy” because it is not sold in the form of a bar, drop, or piece. Cotton candy is, however, “prepared food” under Iowa Code section 423.3(57) “f.”

d. Flour. In order for a product to be treated as containing “flour,” the product label must specifically list the word “flour” as one of the ingredients. There is no requirement that the “flour” be grain-based, and it does not matter what the flour is made from. Many products that are commonly thought of as “candy” contain flour, as indicated on the ingredient label and therefore are specifically excluded from the definition of “candy.” Ingredient labels must be examined to determine which products contain flour and which products do not contain flour. Any preparation to which flour has been added only for the purpose of excluding its sales from tax and not for any legitimate purpose, culinary or otherwise, shall not be sold exempt from tax under this rule. For example, a candy bar that contains flour, for a legitimate purpose, is excluded from the definition of “candy.”

EXAMPLE 1: The ingredient list for a breakfast bar lists “flour” as one of the ingredients. This breakfast bar is not “candy” since it contains flour.

EXAMPLE 2: The ingredient list for a breakfast bar lists “peanut flour” as one of the ingredients. This breakfast bar is not “candy” because it contains flour.

EXAMPLE 3: The ingredient list for a breakfast bar that otherwise meets the definition of “candy” lists “whole grain” as one of the ingredients, but does not specifically list “flour” as one of the ingredients. This breakfast bar is “candy” because the word “flour” is not included in the ingredient list.

EXAMPLE 4: Company E sells a box of chocolates that are not individually wrapped. The ingredient list on the label for the box of chocolates identifies flour as one of the ingredients. The box of chocolates is not “candy” since flour is identified as one of the ingredients on the label.

EXAMPLE 5: Company F sells a box of chocolates that are not individually wrapped. The ingredient list on the label for the box of chocolates, which otherwise meets the definition of “candy,” does not identify flour as one of the ingredients. The box of chocolates is “candy.”

EXAMPLE 6: Company G sells high-end licorice—licorice A and licorice B. Licorice A would otherwise be “candy,” but its wrapper lists “flour” as an ingredient. Licorice A is not “candy.” Licorice B is the same as licorice A, except it does not contain “flour.” Licorice B is “candy.”

e. Other ingredients or flavorings. “Other ingredients or flavorings” as used in this rule means other ingredients or flavorings that are similar to chocolate, fruits or nuts. This phrase includes candy coatings such as carob, vanilla and yogurt; flavorings or extracts such as vanilla, maple, mint, and almond; and seeds and other items similar to the classes of ingredients or flavorings. This phrase does not include meats, spices, seasonings such as barbeque or cheddar flavor, or herbs which are not similar to the classes of ingredients or flavorings associated with chocolate, fruits, or nuts, unless the product otherwise meets the definition of “candy.”

EXAMPLE 1: Retailer A sells barbeque-flavored peanuts. The ingredient label for the barbeque-flavored peanuts indicates that the product contains peanuts, sugar and various other ingredients, including barbeque flavoring. Since the barbeque-flavored peanuts contain a combination of sweeteners and nuts, and flour is not listed on the label and the nuts do not require refrigeration, barbeque-flavored peanuts are “candy.”

EXAMPLE 2: Retailer B sells barbeque potato chips. Potato chips are potatoes, a vegetable, and are not commonly thought of as candy. The barbeque potato chips are “food and food ingredients” and not “candy.” The fact that the ingredient label for the barbeque potato chips indicates that the product contains

barbeque seasoning which contains a sweetener does not change the fact that the barbeque potato chips are not commonly thought of as candy.

f. Sweeteners. The term “natural or artificial sweeteners” as used in this rule means an ingredient of a food product that adds a sugary sweetness to the taste of the food product and includes, but is not limited to, corn syrup, dextrose, invert sugar, sucrose, fructose, sucralose, saccharin, aspartame, stevia, fruit juice concentrates, molasses, evaporated cane juice, rice syrup, barley malt, honey, maltitol, agave, and artificial sweeteners.

g. Refrigeration. A product that otherwise meets the definition of “candy” is not “candy” if it requires refrigeration. A product “requires refrigeration” if it must be refrigerated at the time of sale or after being opened. In order for a product to be treated as requiring refrigeration, the product label must indicate that refrigeration is required. If the label on a product that contains multiple servings indicates that it “requires refrigeration,” smaller size packages of the same product are also considered to “require refrigeration.” A product that otherwise meets the definition of “candy” is “candy” if the product is not required to be refrigerated, but is sold refrigerated for the convenience or preference of the customer, retailer, or manufacturer.

EXAMPLE 1: Company A sells sweetened fruit snacks in a bag that contains multiple servings. The label on the bag indicates that after opening, the sweetened fruit snacks must be refrigerated. The sweetened fruit snacks “require refrigeration.”

EXAMPLE 2: Company A sells sweetened fruit snacks in single-serving containers. Other than for packaging, the sweetened fruit snacks are identical to the sweetened fruit snacks in Example 1 above. However, since this container of sweetened fruit snacks only contains one serving, it is presumed that it will be used immediately, and the label does not indicate that after opening, the product must be refrigerated. Even though the label does not contain the statement that after opening the sweetened fruit snacks must be refrigerated, these sweetened fruit snacks are considered to “require refrigeration.”

EXAMPLE 3: Company A sells chocolate truffles. The label on the truffles indicates to keep the product cool and dry, but does not indicate that the product must be refrigerated. Since the chocolate truffles are not required to be refrigerated, even though the label indicates to keep them cool, the chocolate truffles do not “require refrigeration.”

231.4(2) Nonexclusive examples.

a. Taxable candy. Examples of items taxable as candy include, but are not limited to: preparations of fruits, nuts, or other ingredients in combination with sugar, honey, or other natural or artificial sweeteners in the form of bars, drops, or pieces; caramel-coated or other candy-coated apples or other fruit; candy-coated popcorn; hard or soft candies including jellybeans, taffy, licorice not containing flour, marshmallows, and mints; dried fruit leathers or other similar products prepared with natural or artificial sweeteners; candy breath mints; chewing gum; and mixes of candy pieces.

Sales of items which are normally sold for use as ingredients in recipes but which can be eaten as candy are taxable on and after July 1, 2004. Examples of these items include, but are not limited to: sweetened baking chocolate in bars or pieces; white and dark chocolate almond bark; toffee bits; M&M's, including those sold for baking; candy primarily intended for decorating baked goods; and sweetened baking chips, including mint chips, peanut butter chips, butterscotch chips, and chocolate chips.

b. Nontaxable items. Sales of the following are generally not taxable as candy: jams, jellies, preserves, or syrups; frostings; dried fruits without added sweetener; breakfast cereals; prepared fruit in a sugar or similar base; ice cream or other frozen desserts covered with chocolate or similar coverings; cotton candy; cakes, cookies, and similar products covered with chocolate or other similar coating; and granola bars. However, these and similar items are taxable if sold as prepared food under rule 701—231.5(423).

231.4(3) Bundled transaction including candy.

a. Candy and food. Products that are a combination of items that are defined as “candy” under this rule and items that are defined as “food and food ingredients” under rule 701—231.3(423) are “bundled transactions” when the items are distinct and identifiable and are sold for one nonitemized price, unless the seller’s sales price or purchase price of the candy accounts for 50 percent or less of the seller’s sales

price or purchase price of the bundled transaction as provided under Iowa Code section 423.2(8) “d”(4). For example, a bag of multiple types of individually wrapped bars that is sold for one price is two or more distinct and identifiable products sold for one nonitemized price. For purposes of determining whether such a bag of individually wrapped bars is a “bundled transaction,” the following criteria apply:

(1) Ingredients listed separately.

1. If a package contains individually wrapped bars, drops, or pieces and the product label on the package separately lists the ingredients for each type of bar, drop, or piece included in the package, those bars, drops, or pieces that have “flour” listed as an ingredient are “food and food ingredients” and those bars, drops, or pieces which do not have “flour” listed as an ingredient are “candy.” The determination of whether the package as a whole meets the definition of “bundled transaction” is based on the percentage of bars, drops, or pieces that meet the definition of “food and food ingredient” as compared to the percentage of bars, drops, or pieces that meet the definition of “candy.”

2. Determining the percentage. For purposes of determining the percentage of the sales price or purchase price of the bars, drops, or pieces that meet the definition of “candy” as compared to all of the bars, drops, or pieces contained in the package, the retailer may presume that each bar, drop, or piece contained in the package has the same value.

3. Presumption of product amount. A retailer may presume that there is an equal number of each type of product contained in the package, unless the package clearly indicates otherwise.

EXAMPLE: Retailer B sells bulk food and food ingredients by the pound. Each food and food ingredient is in a separate bin or container. Some of the food and food ingredients are “candy” and some of them are not because they contain flour. However, regardless of the items chosen, the retailer charges the customer \$3.49/lb. Customer C selects some items that are “candy” and some that are not and puts them in a bag. Since some of the items in the bag are “candy,” the retailer shall treat the entire package as a bundled transaction containing primarily “candy,” unless the retailer ascertains that the sales price or purchase price of the candy in the bag is less than 50 percent of the sales price or purchase price of the entire bag. See Iowa Code section 423.2(8).

(2) Ingredients listed together. If a package contains individually wrapped bars, drops, or pieces and all of the ingredients for each of the products included in the package are listed together, as opposed to being listed separately by each product included as explained in subparagraph (1) above, and even if the ingredient lists “flour” as an ingredient, the product will be treated as “candy,” unless the retailer is able to ascertain that the sales price or purchase price of the candy in the package is less than 50 percent of the sales price or purchase price of the entire bag. See Iowa Code section 423.2(8).

The retailer may presume that each bar, drop, or piece contained in the package has the same value. The retailer may presume that there is an equal number of each type of product contained in the package, unless the package clearly indicates otherwise.

b. Combination of ingredients. Products whose ingredients are a combination of various unwrapped food ingredients that alone are not “candy,” along with unwrapped food ingredients that alone are “candy,” such as breakfast cereal and trail mix with candy pieces, are considered “food and food ingredients” and are not “candy.” Sales of these products are not “bundled transactions” because there are not two or more distinct and identifiable products being sold. The combination of the ingredients results in a single product.

This rule is intended to implement Iowa Code sections 423.2(8) and 423.3(57).

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701—231.5(423) Sales of prepared food. On and after July 1, 2004, sales of “prepared food” are subject to tax as such sales were taxable prior to that date. However, before and after that date, the definitions of “prepared food” differ slightly. Reference rule 701—20.5(423) for a description of the taxation of “prepared food” prior to July 1, 2004.

231.5(1) Prepared food.

a. On and after July 1, 2004, “prepared food” means any of the following:

- (1) Food sold in a heated state or heated by the seller, including food sold by a caterer.

- (2) Two or more food ingredients mixed or combined by the seller for sale as a single item.
- (3) Food sold with eating utensils provided by the seller, including plates, knives, forks, spoons, glasses, cups, napkins, or straws. A plate does not include a container or packaging used to transport food.

The types of retailers who are generally considered to be offering prepared food for sale include restaurants, coffee shops, cafeterias, convenience stores, snack shops, and concession stands including those at recreation and entertainment facilities. Other retailers that often offer prepared food include vending machine retailers, mobile vendors, and concessionaires operating facilities for such activities as education, office work, or manufacturing.

If food is sold for consumption on the premises of a retailer, the food is rebuttably presumed to be prepared food. "Premises of a retailer" means the total space and facilities under control of the retailer or available to the retailer, including buildings, grounds, and parking lots that are made available or that are available for use by the retailer, for the purpose of sale of prepared food and drink or for the purpose of consumption of prepared food and drink sold by the retailer. Availability of self-service heating or other preparation facilities or eating facilities such as tables and chairs and knives, forks, and spoons, indicates that food, food products, and drinks are sold for consumption on the premises of the retailer and are subject to tax as sales of prepared food.

The following examples are intended to show some of the situations in which sales are taxable as sales of prepared food and drink.

EXAMPLE A. A movie theater owner operates a movie theater and a concession stand in the lobby of the theater. There is not a separate area set aside for eating facilities. Sales of prepared food and drink through the concession stand are taxable.

EXAMPLE B. As a convenience to employees, a manufacturer owns and operates several food and drink vending machines located on the premises of the plant. No separate seating or other facilities for eating are provided. Sales of prepared food and drink through the vending machines are taxable.

EXAMPLE C. Mobile vendor units located throughout an office are operated by the owner of the business and are stocked with snack food priced to cover the cost of the items to the employer. No separate eating facilities are provided. Sales of prepared food through the mobile vendors are taxable.

EXAMPLE D. An insurance company hires a caterer to run a cafeteria which provides food, at a low cost, to its employees. The insurance company also pays the caterer an amount, per month, which varies with the number of meals the caterer serves to provide this food service. The caterer does not lease the cafeteria premises; thus the premises remains under the control of the insurance company. In this case, the caterer sells the food in a space made "available to the retailer [caterer]," and the amount which the insurance company pays, on a monthly basis, to the caterer is presumed to be the taxable sales price from the sale of prepared food, as well as the amount paid by the employees to the caterer.

- b.* "Prepared food," for the purposes of this rule, does not include food that is any of the following:
 - (1) Only cut, repackaged, or pasteurized by the seller.
 - (2) Eggs, fish, meat, poultry, and foods containing these raw animal foods requiring cooking by the consumer as recommended by the United States Food and Drug Administration in Chapter 3, Part 401.11 of its Food Code, so as to prevent food-borne illnesses.
 - (3) Bakery items sold by the seller that baked them. The term "bakery items" includes but is not limited to breads, rolls, buns, biscuits, bagels, croissants, pastries, donuts, Danish, cakes, tortes, pies, tarts, muffins, bars, cookies, and tortillas. On and after July 1, 2004, baked goods sold for consumption on the premises by the seller that baked them are sold exempt from tax. This is a change from previous law; reference 701—subrule 20.5(2), Example D.
 - (4) Food sold in an unheated state as a single item without eating utensils provided by the seller which is priced by weight or volume.

231.5(2) Examples. The following are additional examples of foods that either are or are not "prepared foods," the sales price of which is taxable.

EXAMPLE A: A supermarket retailer cuts Bibb and romaine lettuce, mixes them together, and places them in a bag for sale. This is food which is only cut and repackaged. Its sale is not the sale of prepared food; thus its sale is exempt from tax.

EXAMPLE B: The same factual situation as Example A above applies, except that the lettuce is mixed with a salad dressing, placed in a container, and sold as a salad which is ready to eat. Sale of the salad is a taxable sale of “prepared food.”

EXAMPLE C: A supermarket retailer slices a roll of cotto salami and a roll of regular salami. The retailer places ten slices of each in the same container and sells the combination as an Italian luncheon meat variety pack. This is, again, the sale of food which is only cut and repackaged. The sale of the salami is exempt from tax.

EXAMPLE D: The same factual circumstances as in Example C apply, except that the retailer takes the sliced salami, places it between two slices of bread, adds some condiments, surrounds the meat, bread, and condiments with plastic, and sells the result as a ready-to-eat sandwich. This is prepared food, “two or more food ingredients . . . combined by the seller for sale as a single item,” and more is done to the ingredients than cutting and repackaging. Sales of the sandwiches are taxable.

This rule is intended to implement 2005 Iowa Code subsection 423.3(56).

701—231.6(423) Prescription drugs, medical devices, oxygen, and insulin. Sales of prescription drugs and medical devices as defined in subrule 231.6(1) and dispensed for human use or consumption in accordance with subrules 231.6(3) and 231.6(4) shall be exempt from sales tax. Rentals of medical devices as defined in subrule 231.6(1) are also exempt from tax. The sales price from the sales of any oxygen or insulin purchased for human use or consumption (whether or not the oxygen or insulin is prescribed) is exempt from tax.

231.6(1) Definitions.

“*Medical device*” means durable medical equipment or mobility enhancing equipment intended to be prescribed by a practitioner for human use. See rule 701—231.8(423) for definitions of those terms.

“*Prescription drug*” means a drug intended to be dispensed to an ultimate user pursuant to a prescription drug order, formula, or recipe issued in any form of oral, written, electronic, or other means of transmission by a duly licensed practitioner, or oxygen or insulin dispensed for human consumption with or without a prescription drug order or medication order.

“*Ultimate user*” means any individual who has lawfully obtained and possesses a prescription drug or medical device for the individual’s own use or for the use of a member of the individual’s household, or an individual to whom a prescription drug or medical device has been lawfully supplied, administered, dispensed or prescribed. The phrase does not include any entity created by law, such as a corporation or partnership.

231.6(2) Tax exemption. The sale of a prescription drug is exempt from tax only if the drug is intended to be prescribed or dispensed to an ultimate user. A drug is intended to be prescribed or dispensed to an ultimate user only if the drug is obtained by or supplied or administered to an ultimate user for placement on or in the ultimate user’s body.

EXAMPLE A: A physician prescribes a tranquilizer for a patient who is chronically nervous. The patient uses the prescription to purchase the tranquilizer at a pharmacy. The purchase is exempt from tax.

For purposes of this subrule, any drug prescribed in writing by a licensed physician, surgeon, osteopath, osteopathic physician or surgeon, or other person authorized by law to an ultimate user for human use or consumption shall be deemed a drug exempt from tax if a prescription is required or permitted under Iowa state or federal law.

EXAMPLE B: A common painkiller is sold over the counter in doses of 200 milligrams per tablet. In doses of 600 milligrams per tablet, federal law requires a prescription before the drug can be dispensed. Sales of 600 milligram tablets by prescription are exempt from tax.

EXAMPLE C: A federal law permits but does not require the painkiller mentioned in Example B to be prescribed by a practitioner in dosages of 200 milligrams per tablet. A practitioner might prescribe the painkiller in the over-the-counter dosage, for example, to impress upon a patient the importance of taking the drug. Sales of 200 milligram tablets by prescription are exempt from tax.

See rules 701—231.7(423) and 701—231.8(423) for examples of medical devices sold without a prescription but exempt from tax.

231.6(3) *Persons authorized to dispense prescription drugs or prescription devices.* In order for a prescription drug or device to qualify for an exemption, it must be dispensed by one of the following persons:

- a. Any store or other place of business where prescription drugs are compounded, dispensed or sold by a person holding a license to practice pharmacy in Iowa, and where prescription orders for prescription drugs or devices are received or processed in accordance with pharmacy laws.
- b. Persons licensed by the state board of medical examiners to practice medicine or surgery in Iowa.
- c. Persons licensed by the state board of medical examiners to practice osteopathic medicine or surgery in Iowa.
- d. Persons licensed by the state board of podiatry examiners to engage in the practice of podiatry in Iowa.
- e. Persons licensed by the state board of dental examiners to practice dentistry in Iowa.
- f. Persons licensed by the state board of optometry examiners as therapeutically certified optometrists.
- g. Persons licensed by the state board of chiropractic examiners to practice chiropractic in Iowa, when dispensing in accordance with Iowa Code chapter 151.
- h. Persons licensed as advanced registered nurse practitioners by the board of nursing when prescribing and dispensing in accordance with Iowa Code subsection 147.107(8).
- i. Any other person authorized under Iowa law to dispense prescription drugs or devices in this state.
- j. Any person licensed in another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs or devices.

231.6(4) *Disposition of prescription drugs and devices.* Prescription drugs or devices may be dispensed either directly from one of the persons licensed in 231.6(3) who may also prescribe drugs or devices or by a pharmacist upon receipt of a prescription from one of the persons licensed to prescribe. A prescription received by a licensed pharmacist from one of the persons licensed in 231.6(3) who may also prescribe drugs or devices shall be sufficient evidence that a drug or device is exempt from sales tax. When a person who prescribes a drug or device is also the dispenser, the drug or device will not require a prescription by such person, but the drug or device must be recorded as if a prescription would have been issued or required. If this condition is met, the sales price from the sale of the drug or device shall be exempt from sales tax.

231.6(5) *Others required to collect sales tax.* Any person other than those who are allowed to dispense drugs or devices under 231.6(3) shall be required to collect sales tax on any prescription drugs or devices.

231.6(6) *Prescription drugs and devices purchased by hospitals for resale.* This subrule applies to for-profit hospitals only. Hospitals have purchased prescription drugs or devices for resale to patients and not for use or consumption in providing hospital services only if the following circumstances exist: (a) the drug or device is actually transferred to the patient; (b) the drug or device is transferred in a form or quantity capable of a fixed or definite price value; (c) the hospital and the patient intend the transfer to be a sale; and (d) the sale is evidenced in the patient's bill by a separate charge for the identifiable drug or device. Reference rule 701—18.31(422,423) for a discussion generally of sales for resale by persons performing a service. Also reference rule 701—18.59(422,423) for the exemption applicable to all purchases of goods and services by a nonprofit hospital licensed under Iowa Code chapter 135B.

EXAMPLE A: A hospital purchases a bone saw blade and uses the blade to cut the bone of patient X during hip replacement surgery. This dulls the blade to the point that the blade cannot be used again and is discarded. The hospital bills patient X for "one bone saw blade—\$30." In spite of the separate charge for an identifiable piece of property, the hospital did not purchase the bone saw blade for resale. The blade was used up by the hospital, not transferred to the ownership of X. Since there was no transfer, there was no sale, thus no purchase for resale.

EXAMPLE B: A hospital buys lotion for use in massages given to patients by a nurse's aide. In spite of the fact that one can argue that a transfer of ownership of the lotion from hospital to patient occurred,

the lotion was not purchased for resale. No real intent to sell the lotion to patients ever existed; the lotion was not transferred to patients in a quantity capable of a definite price value; and there is no separate charge for the lotion.

A hospital's purchase of a prescription drug for purposes other than resale will still be exempt from tax if a drug is intended to be prescribed to an ultimate user and the hospital's use of the drug is otherwise exempt under 231.6(1).

This rule is intended to implement 2005 Iowa Code Supplement subsection 423.3(60).

701—231.7(423) Exempt sales of other medical devices which are not prosthetic devices. A prescription is not required for sales of the medical devices listed in subrule 231.7(1) to be exempt from tax if those devices are purchased for human use or consumption.

231.7(1) Definitions.

"Anesthesia trays" includes, without limit, paracervical anesthesia trays, saddle block anesthesia trays, spinal anesthesia trays, and continuous epidural anesthesia trays.

"Biopsy" means the removal and examination of tissue from a living body, performed to establish a precise diagnosis.

"Biopsy needles" includes, without limit, needles used to perform liver, kidney, other soft tissue, bone, and bone marrow biopsies. Menghini technique aspirating needles, Rosenthal-type needles, and "J" Jamshidi needles are all examples of biopsy needles.

"Cannula" means a tube inserted into a body duct or cavity to drain fluid, insert medication including oxygen, or to open an air passage. Examples are lariat nasal cannulas and ableson cricothyrotomy cannulas.

"Catheter" means a tubular, flexible, surgical instrument used to withdraw fluids from or introduce fluids into a body cavity, or for making examinations. Examples are: Robinson/nelation catheters, all types of Foley catheters (e.g., pediatric and irrigating), three-way catheters, suction catheters, IV catheters, angiocath catheters and male and female catheters.

"Catheter trays." Universal Foley catheter trays, economy Foley trays, urethral catheterization trays and catheter trays with domed covers are nonexclusive examples of these trays.

"Diabetic testing materials" means all materials used in testing for sugar or acetone in the urine, including, but not limited to, Clinitest, Tes-tape, and Clinistix; also, all materials used in monitoring the glucose level in the blood, including, but not limited to, bloodletting supplies and test strips.

"Drug infusion device" means a device designed for the slow introduction of a drug solution into the human body. The term includes devices which infuse by means of pumps or gravity flow (drip infusion).

"Fistula" means an abnormal passage usually between the internal organs or between an internal organ and the surface of the body.

"Hypodermic syringe" means an instrument for applying or administering liquid into any vessel or cavity beneath the skin. This includes the needle portion of the syringe if it accompanies the syringe at the time of purchase, and it also includes replacement needles.

"Insulin" means a preparation of the active principle of the pancreas, used therapeutically in diabetes and sometimes in other conditions.

"Kit" means a combination of medical equipment and supplies used to perform one particular medical procedure which is packaged and sold as a single item.

"Myelogram" means a radiographic picture of the spinal cord. A "radiographic picture" is one taken using radiation other than visible light.

"Nebulizer" means a mechanical device which converts a liquid to a spray or fog.

"Other medical device," for the purposes of this rule, means medical equipment or supplies intended to be dispensed for human use with or without a prescription to an ultimate user.

"Oxygen equipment" means all equipment used to deliver medicinal oxygen including, but not limited to, face masks, humidifiers, cannulas, tubing, mouthpieces, tracheotomy masks or collars, regulators, oxygen concentrators and oxygen accessory racks or stands.

"Set." See "kit" above.

"Tray." See "kit" above.

231.7(2) Sales of the following other medical devices are exempt from tax:

- a. Sales of insulin, hypodermic syringes, and diabetic testing materials.
- b. Sales and rentals of oxygen equipment.
- c. Sales of hypodermic needles, anesthesia trays, biopsy trays and needles, cannula systems, catheter trays, invasive catheters, dialyzers, drug infusion devices, fistula sets, hemodialysis devices, insulin infusion devices, irrigation solutions, intravenous administering sets, solutions and stopcocks, myelogram trays, nebulizers, small vein infusion kits, spinal puncture trays, transfusion sets and venous blood sets, all of which are not taxable.

231.7(3) Component parts. Sales of any component parts of the trays, systems, devices, sets, or kits listed above are taxable unless the sale of a component part, standing alone, is otherwise exempt under these rules. For instance, the sale of a biopsy needle or an invasive catheter will be exempt from tax whether or not it was purchased for use as a component part in a biopsy tray or catheter tray, so long as the needle or catheter will be dispensed for human use to an ultimate user. Conversely, sales of catheter introducers, disposable latex gloves, rayon balls, forceps, and specimen bottles are exempt when those items are sold as part of a catheter tray, but are not exempt when those items are sold individually.

This rule is intended to implement 2005 Iowa Code Supplement subsection 423.3(60).

701—231.8(423) Prosthetic devices, durable medical equipment, and mobility enhancing equipment.

231.8(1) *Prosthetic devices.* Sales or rental of prosthetic devices shall be exempt from sales tax.

231.8(2) *Durable medical equipment and mobility enhancing equipment.* Sales or rental of durable medical equipment and mobility enhancing equipment prescribed for human use which meet the provisions of subrules 231.8(3) and 231.8(4) shall be exempt from sales tax. “Prescribed” refers to a prescription issued in any form of oral, written, electronic, or other means of transmission by any of the persons described in paragraphs “a” through “j” of subrule 231.6(3).

231.8(3) *Definitions.*

a. “*Durable medical equipment*” means equipment, including repair and replacement parts, but does not include mobility enhancing equipment, to which all of the following apply:

1. Can withstand repeated use.
2. Is primarily and customarily used to serve a medical purpose.
3. Generally is not useful to a person in the absence of illness or injury.
4. Is not worn in or on the body.
5. Is for home use only.
6. Is prescribed by a practitioner.

b. “*Mobility enhancing equipment*” means equipment, including repair and replacement parts, but does not include durable medical equipment, to which all of the following apply:

1. Is primarily and customarily used to provide or increase the ability to move from one place to another and which is appropriate for use either in a home or a motor vehicle.
2. Is not generally used by persons with normal mobility.
3. Does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer.

4. Is prescribed by a practitioner.

c. “*Prosthetic device*” means a replacement, corrective, or supportive device including repair and replacement parts for the same worn on or in the body to do any of the following:

1. Artificially replace a missing portion of the body.
2. Prevent or correct physical deformity or malfunction.
3. Support a weak or deformed portion of the body.

The term “prosthetic device” includes, but is not limited to, orthopedic or orthotic devices, ostomy equipment, urological equipment, tracheostomy equipment, and intraocular lenses.

The following is a nonexclusive list of prosthetic devices:

Artificial arteries	Drainage bags	Prescription eyeglasses
Artificial breasts	Hearing aids	Stoma bags
Artificial ears	Ileostomy devices	Tracheal suction catheters
Artificial eyes	Intraocular lenses	Tracheostomy care and
Artificial heart valves	Karaya paste	cleaning starter kits
Artificial implants	Karaya seals	Tracheostomy cleaning
Artificial larynx	Organ implants	brushes
Artificial limbs	Ostomy belts	Tracheostomy tubes
Artificial noses	Ostomy clamps	Urinary catheters
Artificial teeth	Ostomy cleaners	Urinary drainage bags
Cardiac pacemakers	and deodorizers	Urinary irrigation tubing
Contact lenses	Ostomy pouches	Urinary pouches
Cosmetic gloves	Ostomy stoma caps and paste	
Dental bridges and implants	Penile implants	

d. “*Orthotic device*” means a piece of special equipment designed to straighten a deformed or distorted part of the human body, such as corrective shoes or braces. An orthotic device is an orthopedic device.

e. “*Orthopedic device*” means a piece of special equipment designed to correct deformities or to preserve and restore the function of the human skeletal system, its articulations and associated structures. A hot tub or spa is not an orthopedic device.

The following is a nonexclusive list of orthopedic devices:

Abdominal belts	Clavicle splints	Nerve stimulators
Alternating pressure mattresses	Corrective braces	Orthopedic implants
Alternating pressure pads	Corrective shoes	Orthopedic shoes
Anti-embolism stockings	Crutch cushions	Patient lifts
Arch supports	Crutch handgrips	Plaster (surgical)
Arm slings	Crutch tips	Rib belts
Artificial sheepskin	Crutches	Rupture belts
Bone cement	Decubitus prevention devices	Sacroiliac supports
Bone nails	Dorsolumbar belts	Sacrolumbar belts
Bone pins	Dorsolumbar supports	Sacrolumbar supports
Bone plates	Elastic bandages	Shoulder immobilizers
Bone screws	Elastic supports	Space shoes
Bone wax	Exercise devices	Splints
Braces	Head halters	Traction equipment
Canes	Hernia belts	Transcutaneous electrical nerve stimulators (tens units)
Casts	Iliac belts	Trapezes
Cast heels	Invalid rings	Trusses
Cervical braces	Knee immobilizers	Walkers
Cervical collars	Lumbosacral supports	Wheelchairs
Cervical pillows	Muscle stimulators	

f. “*Related devices.*” Sales or rental of devices which are used exclusively in conjunction with prosthetic, orthotic, or orthopedic devices shall be exempt from tax. *Daw Industries, Inc. v. United States*, 714 F.2d 1140 (Fed. Cir. 1983).

g. "Medical equipment and supplies." The scope of the term "medical equipment and supplies" is broader than the terms "prescription drugs" or "medical devices." While all exempt prescription drugs are medical supplies and all exempt medical devices are medical equipment, not all medical equipment and supplies are exempt medical devices or prescription drugs. The following is a nonexclusive list of items which are medical equipment or supplies, but are not prescription drugs or medical devices exempt from tax under subrules 231.6(1), 231.8(1), and 231.8(2) and rule 701—231.7(423). Sales of the following items are generally taxable.

Adhesive bandages	Contact lens solution	Hot water bottles
Aneurysm clips	Convuluted pads	Ice bags
Arterial bloodsets	Corrective pessaries	Ident-a-bands
Aspirators	Cotton balls	Incontinent garments
Athletic supporters	Diagnostic kits	Incubators
Atomizers	Dialysis chairs	Infrared lamps
Autolit	Dialysis supplies	Inhalators
Back cushions	Dietetic scales	Iron lungs
Bathing aids	Disposable diapers	Irrigation apparatus
Bathing caps	Disposable gloves	IV connectors
Bedpans	Disposable underpads	Laminar flow equipment
Bedside rails	Donor chairs	Latex gloves
Bedside tables	Dressings	Leukopheresis pumps
Bedside trays	Dry aid kits for ears	Lymphedema pumps
Bedwetting prevention devices	EKG paper	Manometer trays
Belt vibrators	Ear molds	Massagers
Blood cell washing equipment	Electrodes (other than tens units)	Maternity belts
Blood pack holders	Emesis basins	Medigrade tubing
Blood pack trays	Enema units	Modulung oxygenators
Blood pack units	First-aid kits	Moist heat pads
Blood pressure meters	Foam slant pillows	Myringotomy tubes
Blood processing supplies	Gauze bandages	Nebulizers (hypodermic)
Blood tubing	Gauze packings	Overbed tables
Blood warmers	Gavage containers	Page turning devices
Breast pumps	Geriatric chairs	Pap smear kits
Breathing machines	Grooming aids	Paraffin baths
Cardiac electrodes	Hand sealers	Physicians' instruments
Cardiopulmonary equipment	Hearing aid carriers	Pigskin
Chair lifts	Hearing aid repair kits	Plasma extractors
Clamps	Heart stimulators	Plasma pheresis units
Clip-on ashtrays	Heat lamps	Plastic heat sealers
Commode chairs	Heat pads	Prescribed device repair kits and batteries
Connectors	Hemolators	Respirators
Contact lens cases	Hospital beds	Resuscitators
Sauna baths	Steri-peel	Transfer boards
Security pouches	Stools	Tube sealers
Servipak dialysis supplies	Suction equipment	Underpads
Shelf trays	Sunlamps	Urinals

Shower chairs	Surgical bandages	Vacutainers
Side rails	Surgical equipment	Vacuum units
Sitz bath kit	Suspensories	Vaporizers
Specimen containers	Sutures	Vibrators
Sponges (surgical)	Thermometers	Whirlpools
Stairway elevators	Toilet aids	X-ray film
Staples	Tourniquets	

231.8(4) Power devices. Sales or rental of power devices especially designed to operate prosthetic, orthotic or orthopedic devices shall be exempt from tax. This exemption does not include batteries which can be used to operate a number of devices, but batteries designed solely for use in hearing aids are exempt.

This rule is intended to implement 2005 Iowa Code Supplement subsection 423.3(60).

701—231.9(423) Raffles.

231.9(1) For raffles conducted prior to July 1, 2015. Prior to July 1, 2015, the sales price from the sale of tickets for a raffle conducted at a fair pursuant to Iowa Code section 99B.5 is exempt from sales and use tax.

231.9(2) For raffles conducted on or after July 1, 2015. On or after July 1, 2015, the sales price from the sale of tickets for a raffle licensed and conducted at a fair pursuant to Iowa Code section 99B.24 is exempt from sales and use tax.

This rule is intended to implement 2016 Iowa Code subsection 423.3(62).
[ARC 2512C, IAB 4/27/16, effective 6/1/16]

701—231.10(423) Exempt sales of prizes. The sales price from sales of tangible personal property which will be given as prizes to players in games of skill, games of chance, raffles, and bingo games as defined in and lawful under Iowa Code chapter 99B is exempt from tax. See department of inspections and appeals' 481—Chapters 100 through 106, Iowa Administrative Code, for a description of the games of skill, games of chance, raffles, and bingo games which are lawful. See rule 481—100.6(99B) for a description of the prizes which may be lawfully awarded. A gift certificate is not tangible personal property. If a person wins a gift certificate as a prize and then redeems the gift certificate for merchandise, tax is payable at the time the gift certificate is redeemed. Reference 701—15.16(422,423).

This rule is intended to implement 2005 Iowa Code subsection 423.3(62).

701—231.11(423) Modular homes. Forty percent of the sales price from the sale of a modular home is exempt from tax. A “modular home” is any structure built in a factory, made to be used as a place for human habitation, which cannot be attached or towed behind a motor vehicle and which does not have permanently attached to its body or frame any wheels or axles.

This rule is intended to implement 2005 Iowa Code subsection 423.3(63).

701—231.12(423) Access to on-line computer service. The sales price from charges paid to a provider for access to an on-line computer service is exempt from tax. An “on-line computer service” is one which provides for or enables multiple users to have computer access to the Internet. Also, the furnishing of any contracted on-line service is exempt from Iowa tax if the information is made available through a computer server. The exemption applies to all contracted on-line services, as long as they provide access to information through a computer server.

This rule is intended to implement 2005 Iowa Code subsection 423.3(64).

701—231.13(423) Sale or rental of information services. The sales price from the service of the sale or rental of information services is exempt from tax. This exemption does not repeal by implication the tax on the performance of the services of investment counseling, service charges of all financial institutions,

private employment agencies, test laboratories, detective services, or any other services enumerated by statute. Those services remain taxable; reference 701—Chapter 26 generally.

“Information services” means every business activity, process, or function by which a seller or its agent accumulates, prepares, organizes, or conveys data, facts, knowledge, procedures, and like services to a particular buyer (or its agent) of the information through any tangible or intangible medium. Information accumulated, prepared, or organized for a particular buyer, its agent, a group of buyers, or their agent is an information service even though it may incorporate preexisting components of data or other information.

Information services include, but are not limited to, database files, mailing lists, subscription files, market research, credit reports, surveys, real estate listings, bond rating reports, abstracts of title, bad check lists, broadcasting rating services, wire services, scouting reports, white and yellow page listings, and other similar items of compiled information prepared for a particular customer. The furnishing of artwork (including musical compositions and films), drawings, illustrations, or other graphic material is not the performance of an “information service”; nor does the term include information prepared for general dissemination to the public in the form of books, magazines, newsletters, videotapes or audiotapes, compact discs, or any other medium commonly used to communicate with large numbers of customers. The sale of a book, magazine, or similar item is not the sale of an information service, even if the item contains material of practical use (e.g., in conducting a private, for-profit business) to its purchaser.

The following specific examples illustrate the general principles set out above.

EXAMPLE A. John Doe buys a packaged set of preprinted documents and instructions which anyone may purchase and which is entitled “Legal Eagle.” Mr. Doe prepares his own will by reading the instructions, making choices and filling in the blanks on the preprinted documents. Mr. Doe has purchased tangible personal property and not an information service. His purchase is taxable.

EXAMPLE B. A taxpayer buys a book entitled “Doing Your Own Iowa Individual Income Tax,” which is written by an accountant and is available to any buyer. The taxpayer uses the book to prepare her own IA 1040. Since her purchase contains information prepared for general dissemination to the public in the form of a book, that purchase is a taxable sale of tangible personal property and not an exempt sale of an information service.

EXAMPLE C. The seller provides, for a fee, a weekly bulletin listing information on real estate of use to brokers selling homes in a certain Iowa county. The seller secures the information from a multiple listing service without applying any independent thought during the compiling of that information. The bulletin is useful only to those brokers and not to the general public. Since the bulletin is a “real estate listing” and has been prepared for a particular group of customers and not for the general public, its sale is the sale of an information service rather than the sale of tangible personal property and is thus exempt from tax.

EXAMPLE D. A-1 Corporation sells gourmet meats through the mail. A-1 rents its list of customers to whom it mails its catalog to other retailers that specialize in sales of goods or services to the wealthy. Since the list is a “mailing list” and made available only to a particular group of buyers, its rental is the performance of an exempt information service and not the taxable rental of tangible personal property.

EXAMPLE E. Company E is a tariff bureau which specializes in compiling and preparing tariff schedules. E acquires these schedules from various companies throughout the country. E then provides these schedules to common carriers that subscribe to its service. Its printed tariff schedules are published in bound and loose-leaf form; they may be updated daily. E’s providing the schedules is the performance of an exempt information service because the schedules are compiled for a particular group of customers and they are items of compiled information similar to the files, lists, reports, and other information services named above. E’s services are not subject to tax.

EXAMPLE F. Company F compiles and prints telephone directories. F purchases white and yellow page listings from various telephone companies and uses those listings to make up its directories. F’s purchases of the white and yellow page listings are purchases of an exempt information service. Any sales on F’s part of the directories to the general public would be sales of tangible personal property subject to tax.

EXAMPLE G. Company G purchases the assets of four businesses. The primary asset of each of the businesses is a database containing names, addresses, and other customer information of use to G but not to anyone other than a company similar to G. G transfers the lists to its own computers by way of paper or magnetic tape. G has purchased an exempt information service with its purchases of the four databases.

This rule is intended to implement 2005 Iowa Code subsection 423.3(65).

701—231.14(423) Exclusion from tax for property delivered by certain media. A taxable “sale” of tangible personal property does not occur if the substance of the transaction is delivered to the purchaser digitally, electronically, or by utilizing cable, radio waves, microwaves, satellites, or fiber optics. This exclusion from tax is also applicable to the leasing of tangible personal property, since a lease is classified as a “sale” of tangible personal property for the purposes of Iowa sales and use tax law. The exclusion is not applicable to property delivered by any medium other than those listed above. Sales of items such as artwork, drawings, photographs, music, electronic greeting cards, “canned” software (reference 701—subrule 18.34(1)), entertainment properties (e.g., films, concerts, books, and television and radio programs), and all other digitized products delivered as described above are not taxable, except the exclusion does not repeal by implication the tax on the service of providing pay television. Reference rule 701—26.56(422,423). If an order for a product is placed by way of any of the media described above but the product ordered is delivered by conventional, physical means, e.g., the U.S. Postal Service or common carrier, sale of the product is not excluded from tax under this rule.

The department considers delivery of tangible personal property to a purchaser by way of a “load and leave” transaction to be delivery by the use of conventional physical means. The sales price from the purchase of property delivered through a load and leave transaction is not exempt from tax under this rule. “Load and leave” means delivery to the purchaser by use of a tangible storage media where the tangible storage media is not physically transferred to the purchaser.

This rule is intended to implement 2005 Iowa Code subsection 423.3(66) and Iowa Code chapter 423, subchapter IV.

701—231.15(423) Exempt sales of clothing and footwear during two-day period in August. Tax is not due on the sale or use of a qualifying article of clothing or footwear if the sales price of the article is less than \$100 and the sale takes place during a period beginning at 12:01 a.m. on the first Friday in August and ending at 12 midnight of the following Saturday. For example, in the year 2004, this period began at 12:01 a.m. on Friday, August 6, and ended at 12 midnight on Saturday, August 7. Eligible purchases of clothing and footwear are exempt from local option sales taxes as well as Iowa state sales tax.

231.15(1) Definitions. The following words and terms, when used in this rule, shall have the following meanings, unless the context clearly indicates otherwise.

“*Accessories*” includes, but is not limited to, jewelry, handbags, purses, briefcases, luggage, wallets, watches, cufflinks, tie tacks and similar items carried on or about the human body, without regard to whether worn on the body in a manner characteristic of clothing.

“*Clothing or footwear*” means an article of wearing apparel designed to be worn on or about the human body. For the purposes of this rule, the term does not include accessories or special clothing or footwear or articles of wearing apparel designed to be worn by animals.

“*Eligible property*” means an item of a type, such as clothing, that qualifies for Iowa’s sales tax holiday.

“*Special clothing or footwear*” is clothing or footwear primarily designed for athletic activity or protective use and which is not normally worn except when used for the athletic activity or protective use for which it is designed.

231.15(2) Exempt sales.

a. Required price. The exemption applies to each article of clothing or footwear selling for less than \$100, regardless of how many items are sold on the same invoice to a customer. For example, if a customer purchases two shirts for \$80 each, both items qualify for the exemption even though the

customer's total purchase price (\$160) exceeds \$99.99. The exemption does not apply to the first \$99.99 of an article of clothing or footwear selling for more than \$99.99. For example, if a customer purchases a pair of pants costing \$110, sales tax is due on the entire \$110.

b. Order date and back orders. For the purpose of the sales tax holiday, eligible property qualifies for exemption if: the item is both delivered to and paid for by the customer during the exemption period; or the customer orders and pays for the item and the seller accepts the order during the exemption period for immediate shipment, even if delivery is made after the exemption period. The seller accepts an order when the seller has taken action to fill the order for immediate shipment. Actions to fill an order include placement of an "in date" stamp on a mail order or assignment of an "order number" to a telephone order. An order is for immediate shipment when the customer does not request delayed shipment. An order is for immediate shipment notwithstanding that the shipment may be delayed because of a backlog of orders or because stock is currently unavailable to, or on back order by, the seller.

231.15(3) Taxable sales. This exemption does not apply to sales of the following goods or services:

a. Any special clothing or footwear that is primarily designed for athletic activity or protective use and that is not normally worn except when used for the athletic activity or protective use for which it is designed. For example, golf cleats and football pads are primarily designed for athletic activity or protective use and are not normally worn except when used for those purposes; therefore, they do not qualify for the exemption. However, tennis shoes, jogging suits, and swimsuits are commonly worn for purposes other than athletic activity and qualify for the exemption.

b. Accessories, including jewelry, handbags, purses, briefcases, luggage, umbrellas, wallets, watches, and similar items carried on or about the human body, without regard to whether they are worn on the body in a manner characteristic of clothing.

c. The rental of any clothing or footwear. For example, this exemption does not apply to rentals of formal wear, costumes, diapers, and bridal gowns, but would apply to sales of the above items.

d. Taxable services performed on clothing or footwear, such as garment and shoe repair, dry cleaning or laundering, and alteration services. Sales tax is due on alterations to clothing, even though the alteration service may be performed, invoiced and paid for at the same time as the clothing is being purchased. If a customer purchases a pair of pants for \$90 and pays \$15 to have the pants cuffed, the \$90 charge for the pants is exempt, but tax is due on the \$15 alteration charge.

e. Purchases of items used to make, alter, or repair clothing or footwear, including fabric, thread, yarn, buttons, snaps, hooks, belt buckles, and zippers.

231.15(4) Special situations.

a. Articles normally sold as a unit. Articles that are normally sold as a unit must continue to be sold in that manner if the exemption is to apply; they cannot be priced separately and sold as individual items in order to obtain the exemption. For example, if a pair of shoes sells for \$150, the pair cannot be split in order to sell each shoe for \$75 to qualify for the exemption. If a suit is normally priced at \$225 and sold as a unit on a single price tag, the suit cannot be split into separate articles so that any of the components may be sold for less than \$100 in order to qualify for the exemption. However, components that are normally priced as separate articles (e.g., slacks and sport coats, and suit coats and suit pants sold separately prior to the two-day period) may continue to be sold as separate articles and qualify for the exemption if the price of an article is less than \$100.

b. Sales of exempt clothing combined with gifts of taxable merchandise. When exempt clothing is sold in a set that also contains taxable merchandise as a free gift and no additional charge is made for the gift, the exempt clothing may qualify for this exemption. For example, a boxed set may contain a tie and a free tie tack. If the price of the set is the same as the price of the tie sold separately, the item being sold is the tie, which is exempt from tax if sold for less than \$100 during the exemption period.

c. Layaway sales. A layaway sale is a transaction in which merchandise is set aside for future delivery to a customer who makes a deposit, agrees to pay the balance of the purchase price over a period of time and, at the end of the payment period, receives the merchandise. Reference rule 701—16.22(422,423) for general information on layaway sales. A sale of eligible property under a layaway sale qualifies for exemption if: final payment on a layaway order is made by, and the property is given to, the purchaser during the exemption period; or the purchaser selects the property and the

retailer accepts the order for the item during the exemption period, for immediate delivery upon full payment, even if delivery is made after the exemption period.

d. Returns. For a 60-day period immediately after the sales tax holiday exemption period, when a customer returns an item that would qualify for the exemption, no credit for or refund of sales tax shall be given unless the customer provides a receipt or invoice that shows tax was paid, or the seller has sufficient documentation to show that tax was paid on the specific item. This 60-day period is set solely for the purpose of designating a time period during which the customer must provide documentation that shows that sales tax was paid on returned merchandise. The 60-day period is not intended to change a seller's policy on the time period during which the seller will accept returns.

e. Different time zones. The time zone of the seller's location determines the authorized time period for a sales tax holiday when the purchaser is located in one time zone and the seller is located in another.

231.15(5) Calculating taxable and exempt sales price—discounts, coupons, buying at a reduced price, and rebates.

a. Discounts. A discount allowed by a retailer and taken on a taxable sale can be used to reduce the sales price of an item. If the discount reduces the sales price of an item to \$99.99 or less, the item may qualify for the exemption. For example, a customer buys a \$150 dress and a \$100 blouse from a retailer offering a 10 percent discount. After applying the 10 percent discount, the final sales price of the dress is \$135, and the blouse is \$90. The dress is taxable (it is over \$99.99), and the blouse is exempt (it is less than \$99.99). Reference rule 701—15.6(422,423) for a definition of the word “discount” and a description of which retailers' reductions in price are discounts which reduce the taxable sales price of items and which are not.

b. Coupons. When a coupon is issued by a retailer and is actually used to reduce the sales price of any taxable item, the value of the coupon is excludable from the tax as a discount if the retailer is not reimbursed for the coupon amount by a third party. Therefore, a retailer's coupon can be used to reduce the sales price of an item to \$99.99 or less in order to qualify for the exemption. For example, if a customer purchases a pair of shoes priced at \$110 with a coupon worth \$20 off, the final sales price of the shoes is \$90, and the shoes qualify for the exemption. A manufacturer's coupon cannot be used to reduce the sales price of an item. Reference 701—subrule 15.6(3).

c. Buy one, get one free or for a reduced price or “two for the price of one” sales. The total price of items advertised as “buy one, get one free,” or “buy one, get one for a reduced price,” or “two for the price of one” cannot be averaged in order for both items to qualify for the exemption. The following examples illustrate how such sales should be handled.

EXAMPLE 1. A retailer advertises pants as “buy one, get one free.” The first pair of pants is priced at \$120; the second pair of pants is free. Tax is due on \$120. Having advertised that the second pair is free, the store cannot ring up each pair of pants for \$60 in order for the items to qualify for the exemption. However, if the retailer advertises and sells the pants for 50 percent off, selling each pair of \$120 pants for \$60, each pair of pants qualifies for the exemption.

EXAMPLE 2. A retailer advertises shoes as “buy one pair at the regular price, get a second pair for half price.” The first pair of shoes is sold for \$100; the second pair is sold for \$50 (half price). Tax is due on the \$100 shoes, but not on the \$50 shoes. Having advertised that the second pair is half price, the store cannot ring up each pair of shoes for \$75 in order for the items to qualify for the exemption. However, if the retailer advertises the shoes for 25 percent off, thereby selling each pair of \$100 shoes for \$75, each pair of shoes qualifies for the exemption.

EXAMPLE 3. A retailer advertises shirts as “buy two for the price of one” for \$140. Tax is due on \$140. Each shirt cannot be rung up as costing \$70. However, as described in Examples 1 and 2 above, the \$140 cost of each shirt can be discounted to bring the price of each shirt within the exemption's limitation.

d. Rebates. Rebates occur after the sale and do not affect the sales price of an item purchased. For example, a customer purchases a sweater for \$110 and receives a \$12 rebate from the manufacturer. The retailer must collect tax on the \$110 sales price of the sweater. Reference 701—subrule 15.6(2) for additional information regarding rebates.

e. Shipping and handling charges. Shipping charges separately stated and separately contracted for (reference rule 701—15.13(422,423) for explanation) are not part of the amount used to determine whether the sales price of an item qualifies it for exemption. Handling charges, however, are part of the amount used to make this determination if it is necessary to pay those charges in order to purchase an item.

231.15(6) *Treatment of various transactions associated with sales.*

a. Rain checks. A rain check allows a customer to purchase an item at a certain price at a later time because the particular item was out of stock. Eligible items purchased during the exemption period using a rain check will qualify for the exemption regardless of when the rain check was issued. However, issuance of a rain check during the exemption period will not qualify an eligible item for the exemption if the item is actually purchased after the exemption period.

b. Exchanges.

(1) If a customer purchases an item of eligible clothing or footwear during the exemption period and later exchanges the item for a similar eligible item (different size, different color, etc.), no additional tax will be due even if the exchange is made after the exemption period.

EXAMPLE. A customer purchases a \$35 shirt during the exemption period. After the exemption period ends, the customer exchanges the shirt for the same shirt in a different size. Tax is not due on the \$35 price of the shirt.

(2) If a customer purchases an item of eligible clothing or footwear during the exemption period and after the exemption period has ended returns the item and receives credit on the purchase of a different item, the appropriate sales tax will apply to the sale of the newly purchased item.

EXAMPLE. A customer purchases a \$35 shirt during the exemption period. After the exemption period ends, the customer exchanges the shirt for a \$35 jacket. Because the jacket was not purchased during the exemption period, tax is due on the \$35 price of the jacket.

(3) If a customer purchases an item of eligible clothing or footwear during the exemption period and later during the exemption period returns the item and purchases a similar but nonexempt item, the purchase of the second item is not exempt from tax.

EXAMPLE. During the exemption period, a customer purchases a \$90 dress that qualifies for the exemption. Later, during the exemption period, the customer exchanges the \$90 dress for a \$150 dress. Tax is due on the \$150 dress. The \$90 credit from the returned item cannot be used to reduce the sales price of the \$150 item to \$60 for exemption purposes.

(4) If a customer purchases an item of eligible clothing or footwear before the exemption period and during the exemption period returns the item and receives credit on the purchase of a different item of eligible clothing or footwear, no sales tax is due on the sale of the new item if it is purchased during the exemption period and otherwise meets the qualifications for exemption.

EXAMPLE. Before the exemption period, a customer purchases a \$60 dress. Later, during the exemption period, the customer exchanges the \$60 dress for a \$95 dress. Tax is not due on the \$95 dress because it was purchased during the exemption period and otherwise meets the qualifications for the exemption.

231.15(7) *Nonexclusive list of exempt items.* The following is a nonexclusive list of clothing or footwear, sales of which are exempt from tax during the two-day period in August:

Adult diapers	Formal clothing—sold not rented	Raincoats and hats
Aerobic clothing	Fur coats and stoles	Religious clothing
Antique clothing	Galoshes	Riding pants
Aprons—household	Garters and garter belts	Robes
Athletic socks	Girdles	Rubber thongs—“flip-flops”
Baby bibs	Gloves—cloth, dress and leather	Running shoes without cleats
Baby clothes—generally	Golf clothing—caps, dresses, shirts and skirts	Safety shoes (adaptable for street wear)
Baby diapers	Graduation caps and gowns—sold not rented	Sandals
Baseball caps	Gym suits and uniforms	Shawls
Bathing suits	Hats	Shirts
Belts with buckles attached	Hiking boots	Shoe inserts and laces
Blouses	Hooded (sweat) shirts	Stockings
Boots—general purpose	Hosiery, including support hosiery	Suits
Bow ties	Jackets	Support hose
Bowling shirts	Jeans	Suspenders
Bras	Jerseys for other than athletic wear	Sweatshirts
Bridal apparel—sold not rented	Jogging apparel	Sweatsuits
Camp clothing	Knitted caps or hats	Swim trunks
Caps—sports and others	Lab coats	Tennis dresses
Chefs’ uniforms	Leather clothing	Tennis skirts
Children’s novelty costumes	Leg warmers	Ties
Choir robes	Leotards and tights	Tights
Clerical garments	Lingerie	Trousers
Coats	Men’s formal wear—sold not rented	Tuxedos (except cufflinks)—sold not rented
Corsets	Neckwear, e.g., scarves	Underclothes
Costumes—Halloween, Santa Claus, etc., sold not rented	Nightgowns and nightshirts	Underpants
Coveralls	Overshoes	Undershirts
Cowboy boots	Pajamas	Uniforms—generally
Diapers—cloth and disposable	Pants	Veils
Dresses	Pantyhose	Vests—general, for wear with suits
Dress gloves	Prom dresses	Walking shoes
Dress shoes	Ponchos	Windbreakers
Ear muffs		Work clothes
Employee uniforms other than those primarily designed for athletic activity or protective use		

231.15(8) *Nonexclusive list of taxable items.* The following is a nonexclusive list of items, sales of which are taxable during the two-day period in August:

Accessories—generally	Fabric sales	Safety clothing
Alterations of clothing	Fishing boots (waders)	Safety glasses
Athletic supporters	Football pads	Safety shoes—not adaptable for street wear
Backpacks	Football pants	Shoes with cleats or spikes
Ballet shoes	Football shoes	Shoulder pads for dresses and jackets
Barrettes	Goggles	Shower caps
Baseball cleats	Golf gloves	Skates—ice and roller
Baseball gloves	Ice skates	Ski boots, masks, suits and vests
Belt buckles sold without belts	In-line skates	Special protective clothing or footwear not adaptable for streetwear
Belts for weight lifting	Insoles	Sports helmets
Belts needing buckles but sold without them	Jewelry	Sunglasses—except prescription
Bicycle shoes with cleats	Key cases and chains	Sweatbands—arm, wrist and head
Billfolds	Knee pads	Swim fins, masks and goggles
Blankets	Laundry services	Tap dance shoes
Boutonnieres	Life jackets and vests	Thread
Bowling shoes—rented and sold	Luggage	Vests—bulletproof
Bracelets	Monogramming services	Weight lifting belts
Buttons	Pads—elbow, knee and shoulder, football and hockey	Wrist bands
Chest protectors	Patterns	Yard goods
Clothing repair	Protective gloves and masks	
Coin purses	Purses	
Corsages	Rental of clothing	

Dry cleaning services	Rental of shoes or skates	Yarn
Elbow pads	Repair of clothing	Zippers
Employee uniforms primarily designed for athletic activities or protective use	Roller blades	

This rule is intended to implement 2005 Iowa Code subsection 423.3(67).

701—231.16(423) State sales tax phase-out on energies. Beginning January 1, 2002, the state sales tax is phased out at the rate of 1 percent per year on the sales price from the sale, furnishing, or service of metered natural gas, electricity and fuels, including propane and heating oils, to residential customers for use as energy for residential dwellings, apartment units, and condominiums for human occupancy.

Local option taxes are not included in the phase-out of the state sales tax.

This phase-out of tax does not impact franchise fees. Franchise fees will continue to be imposed where applicable.

231.16(1) Definitions. The following definitions are applicable to this rule:

“*Energy*” means a substance that generates power to operate fixtures or appliances within a residential dwelling or that creates heat or cooling within a residential dwelling.

“*Fuel*” means a liquid source of energy for a residential dwelling, individual apartment unit, or condominium. “*Fuel*” includes propane, heating fuel, and kerosene. However, “*fuel*” does not include blended kerosene used as motor fuel or special fuel.

“*Metered gas*” means natural gas that is billed based on metered usage to provide energy to a residential dwelling, individual apartment unit, or individual condominium.

“*Residential dwelling*” means a structure used exclusively for human occupancy. This does not include commercial or agricultural structures, nor does it include nonresidential buildings attached to or detached from a residential dwelling, such as an outbuilding. However, a garage attached to or detached from a dwelling that is used strictly for residential purposes will fall within the phase-out provisions. A building containing apartment units is not considered to be qualifying property for purposes of this rule. However, if each apartment has a separate meter, it may qualify for the phase-out if classified as qualifying property by the utility. Also excluded from the phase-out provisions are certain nonqualifying properties that include, but are not limited to, nursing homes, adult living facilities, assisted living facilities, halfway houses, charitable residential facilities, YMCA residential facilities, YWCA residential facilities, apartment units not individually metered, and group homes.

231.16(2) Schedule for phase-out of tax. State sales tax on energies will be phased out at the rate of 1 percent per year based on the following schedule:

a. If the date of the utility billing or meter reading cycle of the residential customer for the sale, furnishing, or service of metered gas and electricity is on or after January 1, 2002, through December 31, 2002, or if the sale, furnishing, or service of fuel for purposes of residential energy and the delivery of the fuel occur on or after January 1, 2002, through December 31, 2002, the rate of state tax is 4 percent of the sales price.

b. If the date of the utility billing or meter reading cycle of the residential customer for the sale, furnishing, or service of metered gas and electricity is on or after January 1, 2003, through December 31, 2003, or if the sale, furnishing, or service of fuel for purposes of residential energy and the delivery of the fuel occur on or after January 1, 2003, through December 31, 2003, the rate of state tax is 3 percent of the sales price.

c. If the date of the utility billing or meter reading cycle of the residential customer for the sale, furnishing, or service of metered gas and electricity is on or after January 1, 2004, through December 31, 2004, or if the sale, furnishing, or service of fuel for purposes of residential energy and the delivery of the fuel occur on or after January 1, 2004, through December 31, 2004, the rate of state tax is 2 percent of the sales price.

d. If the date of the utility billing or meter reading cycle of the residential customer for the sale, furnishing, or service of metered gas and electricity is on or after January 1, 2005, through December 31, 2005, or if the sale, furnishing, or service of fuel for purposes of residential energy and the delivery of

the fuel occur on or after January 1, 2005, through December 31, 2005, the rate of state tax is 1 percent of the sales price.

e. If the date of the utility billing or meter reading cycle of the residential customer for the sale, furnishing, or service of metered gas and electricity is on or after January 1, 2006, or if the sale, furnishing, or service of fuel for purposes of residential energy and the delivery of the fuel occur on or after January 1, 2006, the rate of state tax is 0 percent of the sales price.

231.16(3) Determination of tax rate. Determination of the rate of state tax to be imposed on a transaction depends on the type of energy that is being purchased.

a. Electricity or metered natural gas. If the energy being purchased is either electricity or natural gas, then the rate of tax is governed by either the billing date or meter reading date. For example, ABC natural gas company sends out bills with a billing date of December 31, 2002, to qualifying residential customers. However, the bills to these qualifying customers are not placed in the United States mail until January 2, 2003. Based on the foregoing facts, the state sales tax to be imposed on the bills is 4 percent. Four percent is the tax rate imposed at the time of the billing date on the gas bills sent to the customers.

If a billing for the same usage period needs to be billed more than once due to loss of the original bill or some other error, the billing date of the original bill controls qualification for the phase-out provisions of metered gas or electricity. For example, a utility company issues a billing for metered gas on December 28, 2001, to a customer and the customer loses the billing. The customer calls the utility company on January 10, 2002, to report the lost billing and to request a new billing. The utility company issues a new billing with a billing date of January 12, 2002, to the customer. The original billing date issued to the customer is determinative for the tax rate to be imposed. As a result, a 5 percent state tax rate should be imposed on the billing because the original billing date was prior to January 1, 2002.

b. Fuel and heating oil. The proper rate of tax to be imposed for the sale, furnishing or service of fuel including propane is governed by the date of delivery of the fuel to the customer. Consequently, if a farmer purchases propane for home heating by executing an agreement and paying for the propane in October 2002 but the propane is not delivered to the farmer until January 2003, the rate of state sales tax that should be imposed on the transaction is 3 percent.

231.16(4) Qualifying and nonqualifying usage. Customers that have both qualifying and nonqualifying usage on the same meter or fuel tank are subject to a proration formula to obtain the qualifying portion eligible for the phase-out provisions. In these situations, the percentage of qualifying usage must be determined by the purchaser for the purposes of applying the phase-out tax. Nonqualifying usage would be subject to the full state tax rate. Consequently, a proration of the metered gas, electricity or fuel usage for the qualifying and the nonqualifying usage must be calculated by the purchaser. Reference 701—subrules 15.3(4) and 15.4(5) for guidance on proration of electricity, natural gas and fuels. In addition, the purchaser must furnish an exemption certificate to the supplier with respect to that percentage of metered gas or electricity that is eligible for the phase-out provisions. Reference 701—subrule 15.3(2). The customer may provide a calculation which includes only the usage not subject to phase-out.

The customer must notify the utility provider of the percentage of qualifying and nonqualifying usage and the customer has the burden of proof regarding the percentage. The customer is liable for any mistakes or misrepresentations made regarding the computation or for failure to notify the utility provider in writing of the percentage of qualifying or nonqualifying usage.

Security lights used by customers that are billed as a flat rate tariff will be subject to the phase-out if the customer is classified as a residential customer. However, if a customer uses security lights which are billed as a flat rate tariff and that customer is classified as a commercial customer, the sales price including the usage of the security lights is not subject to the phase-out of state sales tax and is subject to the full state sales tax rate, unless another exemption from state sales tax is applicable.

231.16(5) Reporting over the phase-out period. Sales/use tax returns will be filed on the same basis as they are currently filed. During each phase-out period, the entire sales price from sales should be reported on the return. The appropriate state sales tax rate for the tax period will be applied by claiming the phased-out portion of the tax rate as a deduction on the return.

The sales prices for local option taxes are also to be reported in their entirety and computed by applying the appropriate local option tax rate.

The following are examples regarding how state sales and local option taxes should be reported:

EXAMPLE 1. Reporting of tax by an energy provider:

Sales price for a tax period in 2002	\$100,000
Phase-out (20,000 for the first year, 40,000 for the second year, etc.)	20,000
Taxable sales	80,000
State tax at 5% (to compute state sales tax due)	4,000
Sales price to be reported for local option	100,000
Local option tax rate (assuming a 1% local option tax rate)	× 1%
Local option tax due	1,000
Total tax due (local option and state sales tax)	\$5,000

EXAMPLE 2. Reporting of tax on an individual billing:

Monthly charge during a billing or delivery period in 2002	\$400
State tax rate	× 4%
State tax due	16
Sales price for local option tax	400
Local option tax rate	× 1%
Local option tax due	4
Total tax (local option and state sales tax)	\$20

This rule is intended to implement 2005 Iowa Code section 423.3(68).

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CHAPTER 105
HOLIDAY REST STOPS

761—105.1(307,314) Purpose. The purpose of this chapter is to establish the requirements and procedures for approving requests for rest stops on primary and interstate highways during holiday periods.

[ARC 3561C, IAB 1/3/18, effective 2/7/18]

761—105.2(307) General.

105.2(1) *Holiday rest stop.* A holiday rest stop is a location where a nonprofit organization or group serves free refreshments to motorists during holiday periods to provide a break from driving monotony, promote safer driving, and reduce the potential for highway accidents.

105.2(2) *Free refreshments.* Free refreshments means water, coffee, cookies, any nonintoxicating, noncarbonated beverage which is not already bottled or canned, doughnuts, or baked dessert goods.

105.2(3) *Holiday periods.* Holiday periods shall be limited to:

a. Memorial Day weekend and Labor Day weekend, starting at noon on the preceding Friday and ending at midnight between Monday and Tuesday of the holiday weekend.

b. The period surrounding Independence Day, starting at noon on July 1 and ending at midnight between July 6 and July 7.

105.2(4) *Information.* General information regarding holiday rest stops is available from the Maintenance Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or the department's website at www.iowadot.gov.

[ARC 3561C, IAB 1/3/18, effective 2/7/18; ARC 5607C, IAB 5/5/21, effective 6/9/21]

761—105.3(307,314) Conditions. The sponsor of a holiday rest stop shall comply with the following general conditions:

105.3(1) The sponsor shall not request or accept payment for the refreshments served. The sponsor may accept voluntary donations using containers clearly labeled with a sign stating "donations." If donation containers are used, the sponsor shall place signs within the immediate area of the operation at locations designated by the department stating "free refreshments."

105.3(2) The sponsor shall not distribute any literature or other promotional material.

105.3(3) Rescinded IAB 4/3/02, effective 5/8/02.

105.3(4) The sponsor shall clean up the area and remove all signs it has erected promptly after the holiday rest stop is discontinued.

105.3(5) Parking shall not be permitted on the highway shoulders.

105.3(6) The sponsor shall agree to save the department of transportation and the state of Iowa harmless from any liability that may result from the directing of traffic to the holiday rest stop area, and as a result of changes of traffic patterns caused by the activities of the sponsor in or about the holiday rest stop area, and all other liability related to the operation of the special holiday rest stop and the refreshments provided.

[ARC 3561C, IAB 1/3/18, effective 2/7/18]

761—105.4(307,314) Holiday rest stops on interstate highways.

105.4(1) *Site.* A holiday rest stop along an interstate highway shall be located in an established interstate rest area. The department shall designate an appropriate spot within the rest area for the holiday rest stop. The sponsor shall not use the rest area restroom building or welcome center buildings for the purposes of the holiday rest stop. The sponsor may use the information kiosk where available. A tent or canopy may be used in areas without a kiosk during inclement weather. Running water is available at each rest area. The department will provide electricity if requested.

105.4(2) *Signs.*

a. The sponsor shall not place any signs directing highway traffic to the holiday rest stop. The sponsor shall not place any signs for the holiday rest stop along the interstate highway or interchange

ramps. The department shall place signs stating “free refreshments” adjacent to the interstate highway and shall remove these signs when the holiday rest stop is discontinued.

b. The sponsor is responsible for any signs posted at the actual holiday rest stop site. Signs provided or placed by the sponsor shall not include any advertising but may include the sponsor’s name. Signs shall not be mounted on objects (including vehicles) that contain the name of any organization or individual except the sponsor. The sponsor shall remove all signs it has erected promptly after the holiday rest stop is discontinued.

105.4(3) Request. A request to sponsor a holiday rest stop in an interstate rest area shall be made on Form 810023. This form is available from the maintenance bureau or the department’s website.

a. The request shall include the name and address of the requesting sponsor, a detailed description of the proposed holiday rest stop location, and the requested hours of operation.

b. The request shall be submitted to the maintenance bureau.

c. The request must be submitted at least 30 days prior to the beginning date of the holiday period and shall be accepted up to 12 months in advance.

105.4(4) Approval of request. The request is subject to the approval of the maintenance bureau.

a. A request to sponsor a holiday rest stop shall not be approved until 60 days before the beginning date of the holiday period.

b. If there is more than one qualifying request for the same site and date, the sponsor shall be selected by lottery.

[ARC 3561C, IAB 1/3/18, effective 2/7/18; ARC 5607C, IAB 5/5/21, effective 6/9/21]

761—105.5(307,314) Holiday rest stops on primary highways.

105.5(1) Site. The proposed site of a holiday rest stop along a noninterstate primary highway will be inspected by the department to ensure it meets the following requirements:

a. The site shall be large enough to provide parking space for at least 15 vehicles and located so that all parked vehicles will be at least 50 feet from the edge of the traveled way of the primary highway.

b. An access drive from the primary highway shoulder to the parking area shall have a top width of at least 20 feet and shall provide a clear view of the primary highway for at least 900 feet in each direction.

105.5(2) Signs.

a. The sponsor shall not place any signs directing highway traffic to the holiday rest stop. The sponsor shall provide two signs approximately 4 feet by 4 feet announcing the holiday rest stop, one for each highway approach to the site. These signs will be installed by the department, not the sponsor. The department shall remove these signs when the holiday rest stop is discontinued.

b. The sponsor is responsible for any signs posted at the actual holiday rest stop site. Signs provided or placed by the sponsor shall not include any advertising but may include the sponsor’s name. Signs shall not be mounted on objects (including vehicles) that contain the name of any organization or individual except the sponsor. The sponsor shall remove all signs it has erected promptly after the holiday rest stop is discontinued.

105.5(3) Request. A request to sponsor a holiday rest stop along a noninterstate primary highway shall be made on Form 810023. This form is available from the maintenance bureau or the department’s website.

a. The request shall include the name and address of the requesting sponsor, a detailed description of the proposed holiday rest stop location, and the requested hours of operation.

b. The request shall be submitted to the maintenance bureau.

c. The request must be submitted at least 30 days prior to the beginning date of the holiday period and shall be accepted up to 12 months in advance.

105.5(4) Approval of request. The request is subject to the approval of the maintenance bureau.

a. A request to sponsor a holiday rest stop shall not be approved until 60 days before the beginning date of the holiday period.

b. If there is more than one qualifying request for the same site and date, the sponsor shall be selected by lottery.

[ARC 3561C, IAB 1/3/18, effective 2/7/18; ARC 5607C, IAB 5/5/21, effective 6/9/21]

These rules are intended to implement Iowa Code sections 307.12 and 314.27.

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CHAPTER 106
PROMOTION OF IOWA AGRICULTURAL PRODUCTS AT REST AREAS

761—106.1(307) Purpose. The purpose of this chapter is to establish a program to allow Iowa agricultural products to be promoted at interstate rest areas.

761—106.2(307) Definitions.

“Iowa agricultural product” means a product grown or raised in Iowa.

761—106.3(307) Information. General information regarding agricultural promotions at interstate rest areas is available from the Maintenance Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or the department’s website at www.iowadot.gov.
[ARC 3561C, IAB 1/3/18, effective 2/7/18; ARC 5607C, IAB 5/5/21, effective 6/9/21]

761—106.4(307) Request.

106.4(1) A request to promote an Iowa agricultural product at an interstate rest area shall be made on Form 810059. This form is available from the maintenance bureau or the department’s website.

a. The sponsor of the promotion must be an organization that promotes products grown or raised in Iowa.

b. The request shall include the name and address of the requesting organization, a detailed description of the proposed Iowa agricultural product promotion, and the requested hours of operation.

c. The request shall be submitted to the maintenance bureau.

d. The request must be submitted at least 30 days prior to the beginning date of the promotional period and shall be accepted up to six months in advance.

106.4(2) Approval of request. The request is subject to the approval of the maintenance bureau.

a. A request to promote an Iowa agricultural product at an interstate rest area shall not be approved until 60 days before the beginning date of the promotional period.

b. If there is more than one qualifying request for the same site and date, the sponsor shall be selected by lottery.

c. There may be more than one sponsor per day at each site, provided the first sponsor and the department approve any additional sponsors.

[ARC 3561C, IAB 1/3/18, effective 2/7/18; ARC 5607C, IAB 5/5/21, effective 6/9/21]

761—106.5(307) Time frame. Promotions shall be allowed only during daylight hours. Promotions shall be allowed year-round except for the following holiday periods:

1. Memorial Day weekend and Labor Day weekend, starting at noon on the preceding Friday and ending at midnight between Monday and Tuesday of the holiday weekend.

2. The period surrounding Independence Day, starting at noon on July 1 and ending at midnight between July 6 and July 7.

3. The period surrounding Thanksgiving starting at noon the day before Thanksgiving and ending at midnight between Sunday and Monday of the holiday weekend.

4. The period surrounding Christmas starting at noon on December 23 and ending at midnight between December 26 and December 27.

[ARC 3561C, IAB 1/3/18, effective 2/7/18]

761—106.6(307) Conditions.

106.6(1) Signs.

a. The sponsor shall not place any signs directing highway traffic to the promotion, nor shall it place any signs for the promotion along the interstate highway or interchange ramps.

b. The sponsor may provide two signs approximately 4 feet by 4 feet announcing the promotion. If the signs meet the department’s specifications, the signs shall be installed by the department, not by the sponsor. The department shall remove these signs when the promotion is over.

106.6(2) Promotion. A sponsor may distribute literature only if it is directly related to the promoted Iowa agricultural product.

106.6(3) *Sample restrictions.*

- a. Samples must be Iowa agricultural products.
- b. Samples shall be for free distribution only; no sales or donations shall be allowed.
- c. No bread or buns shall be served with food samples.
- d. Food samples shall be no larger than approximately 1-inch cubes.
- e. Beverage samples shall be no larger than 6 ounces.
- f. Water may be provided as a beverage with samples.

106.6(4) *Liability.* The sponsor shall save the department of transportation and the state of Iowa harmless from any liability that may result from the directing of traffic to the promotion, and as a result of changes of traffic patterns caused by the activities of the sponsor in or about the rest area, and all other liability related to the operation of the promotion at the rest area.

106.6(5) *Miscellaneous.*

- a. Live animals are not allowed.
- b. Alcoholic beverages are not allowed.
- c. The sponsor is responsible for litter pickup and disposal.

761—106.7(307) *Site location.* The department shall designate an appropriate spot within the interstate rest area for the promotion. The sponsor shall not use the rest area restroom building or welcome center buildings for the purposes of the promotion. The sponsor may use the information kiosk where available. A tent or canopy may be used in areas without a kiosk during inclement weather. Running water is available at each rest area. The department will provide electricity to the first sponsor if requested. However, electrical outlets are limited and may not be available to additional sponsors.

These rules are intended to implement Iowa Code section 307.12 and 1995 Iowa Acts, chapter 18, section 2.

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