

State of Iowa

Iowa
Administrative
Code
Supplement

Biweekly
June 1, 2011



STEPHANIE A. HOFF
ADMINISTRATIVE CODE EDITOR

Published by the
STATE OF IOWA
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

City Development Board[263]

Replace Chapters 7 and 8

Human Services Department[441]

Replace Chapter 79

Replace Chapter 92

Natural Resource Commission[571]

Replace Analysis

Replace Chapter 14

Replace Chapter 44

Replace Chapter 61

Replace Chapter 65 with Reserved Chapter 65

Public Health Department[641]

Replace Chapter 88

Replace Chapter 126

Replace Chapter 155

Professional Licensure Division[645]

Replace Analysis

Replace Chapters 31 to 33

Pharmacy Board[657]

Replace Chapter 8

CHAPTER 7
VOLUNTARY ANNEXATION

263—7.1(368) When board approval required. Applications for voluntary annexation of territory within another city's urbanized area and voluntary annexation requests including some property without the owner's consent must be approved by both the city receiving the territory and the city development board.

263—7.2(368) Contents of request. A request for board approval of an application for voluntary annexation of territory within another city's urbanized area shall be initiated pursuant to Iowa Code section 368.7 and shall include the following:

7.2(1) Landowner's application. Written application(s) for annexation of the territory must include:

a. A request for annexation of identified property, dated and signed by all owners of record or their authorized representatives;

(1) In the event that voluntary annexation is sought for a parcel of land which is being sold on contract, the contract seller and the contract buyer must both approve the annexation application;

(2) In the event that property for which annexation is sought is owned by a business organization or entity other than a natural person or persons, documentation establishing that the applicant is authorized to act on behalf of the owner shall be provided with the application.

b. A legal description of the property for which annexation is sought; and

c. A map of the property for which annexation is sought.

7.2(2) Documentation of the city's approval of the application. The following documentation must be included in a city's request for board approval of a voluntary annexation application:

a. A general statement of the proposal, briefly describing the current and expected use of the annexation territory, any services which the city currently provides to the territory, and the reasons for the property owners' request for annexation, if known.

b. A statement indicating whether the annexation territory is subject to an existing moratorium agreement and, if so, whether the proposed annexation is consistent with the terms of that agreement.

c. A complete legal description of the territory for which application is made, including the right-of-way to the center line of all secondary roads adjoining the annexation territory, unless a 28E agreement between the county and the city allowing exclusion of the right-of-way is in place and a copy of the agreement is included with the application, as required by Iowa Code section 368.1(14).

d. Prior to approval of a voluntary annexation application by the city council, the city shall provide a copy of the landowner's annexation application and the legal description of the entire annexation territory to the county auditor with a request that the auditor verify the accuracy and completeness of the legal description and verify current ownership of the parcel(s) involved. The auditor's response shall be included in the city's filing with the board. If the auditor fails to respond to the request within 14 days, the city may provide a copy of the request and a statement indicating that no response was received in lieu of the auditor's verification.

e. A map clearly showing the entire boundary of the existing city, the entire annexation territory, adjacent roadways, and the relationship of the territory to the annexing city and, if the annexation territory is within the urbanized area of another city, the relationship of the territory to the neighboring city. More than one map may be submitted if necessary to provide all of the required information to the board.

f. A statement indicating whether state-owned property or county-owned road right-of-way has been included in the proposal pursuant to Iowa Code section 368.5 and, if so, certification that the city has complied with the notice requirement of that section.

g. Certification that the city has complied with the notice requirements of Iowa Code section 368.7, including proof of mailing of the application and affidavit of publication of the required public notice, and, if railway right-of-way is included or public land is included without the written consent of the agency with jurisdiction over the public land, certification of notice to the owner as required by Iowa Code section 368.7(1). For purposes of calculating the required period of notice, "business days" shall

include Monday through Friday of each week, excluding “legal holidays” as set forth in Iowa Code section 4.1(34).

h. The city may, but is not required to, include a provision for transition of the imposition of city taxes against property within the annexation territory. The provision shall not allow greater exemption for taxation than the tax exemption formula schedule provided under Iowa Code section 427B.3, subsections 1 through 5, and shall be applied in the levy and collection of taxes. The provision may also allow for the partial provision of city services during the time in which the exemption from taxation is in effect.

i. A resolution of the council of the city to which the application for annexation is directed approving the application. If the council opts to provide for transition of the imposition of city taxes, the terms of the transition shall be included in the resolution.

j. A statement indicating whether the city has applied smart planning principles to the territory and, if applicable, a description of how the city has applied, or intends to apply, smart planning principles.

7.2(3) Additional information to accompany requests which include land area without the consent of the owner(s). In addition to the information which must be filed pursuant to subrule 7.2(2), a city’s request that includes property without the consent of the owner(s) must provide the following additional information within the application submitted to the board:

a. The names and addresses of all owners of land included without the owners’ consent and a legal description of all land owned by each nonconsenting owner;

b. Prior to filing the annexation application, the city shall provide a copy of the legal description and map of the annexation territory and the list of property owners identified by the city to the county auditor with a request that the auditor verify the accuracy and completeness of the legal description and verify current ownership of the parcel(s) involved. A copy of the auditor’s response shall be included in the application. If the auditor fails to respond to the request within 14 days, the city may provide a copy of the request and a statement indicating that no response was received in lieu of the auditor’s verification;

c. The acreage of each parcel or parcels owned by each voluntary applicant and nonconsenting landowner, the acreage of any railroad right-of-way included pursuant to Iowa Code section 368.7(1), and the acreage of any state- or county-owned property included pursuant to Iowa Code section 368.5;

d. A calculation showing the percentage of the territory for which voluntary annexation applications have been received by the city and the percentage of territory included without the consent of the owner(s), prepared in a manner consistent with subrule 7.8(2);

e. A map indicating the relationship of the parcels included without the consent of the owner(s) to the rest of the territory and to the city;

f. Certification that the city has complied with the notice and public hearing requirements of Iowa Code section 368.7(1). For purposes of calculating the required period of notice, “business days” shall include Monday through Friday of each week, excluding “legal holidays” as set forth in Iowa Code section 4.1(34); and

g. A statement in the city council’s resolution approving the annexation which sets forth the reason(s) that land is included in the proposal without the consent of the owner(s).

[ARC 9278B, IAB 12/15/10, effective 1/19/11; ARC 9546B, IAB 6/1/11, effective 7/6/11]

263—7.3(368) Filing of request. A city seeking board approval of a voluntary annexation application shall file the original and 15 copies of its request and all supporting documentation. The request will be deemed filed with the board on the date it is received by board staff. The board shall return a file-stamped copy of the request to the filing city.

263—7.4(368) Staff review of filing. Within two weeks of a city’s filing of a request for approval of a voluntary annexation, board staff shall review the request to determine whether the city has included all of the information required by rule 7.2(368). If the request is found to be incomplete, staff shall notify the filing city, identifying the required item(s) omitted and offering the city an opportunity to provide the omitted information prior to submission of the request to the board.

263—7.5(368) Submission to the board by staff—notice. A request for the voluntary annexation of property within an urbanized area will be submitted to the board for consideration at the first board meeting conducted 31 or more days after the filing of the request. If no other application for voluntary annexation or petition for involuntary annexation containing common territory is filed with the board within 30 days of the filing of the application, the board will proceed under rule 7.7(368). If another application or petition containing common territory is filed with the board within 30 days, the board will proceed under rule 7.9(368). The board shall provide notice of all meetings at which the board will consider the city's request by regular mail to the filing city, each city whose boundary is within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, each affected public utility, and the regional planning authority which includes the territory. At the request of the annexing city, the board may proceed under rule 7.7(368) at a board meeting less than 31 days after the filing of the application, except that the filings to complete an annexation approved by the board will only be made if no other annexation proposal for any or all of the territory is filed with the board within 30 days of the filing of the application. If a proposal for annexation to another city for all or part of the territory is received within 30 days, the board will proceed under rule 7.9(368).

263—7.6(368) Amendment of application.

7.6(1) *No addition of territory.* After a request for approval of an application for voluntary annexation has been filed with the board, it may not be amended to include additional territory.

7.6(2) *Deletion of territory.* A city may, upon its own motion or at the request of the board, seek amendment of an application for voluntary annexation to delete one or more of the parcels included in the proposal as filed with the board.

a. A motion to amend an application for voluntary annexation may be made at any time prior to issuance of the board order approving or denying the application.

b. The board shall provide notice of a proposed amendment by regular mail to all owners of land included in the application, each city whose boundary is within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, each affected public utility, the regional planning authority which includes the territory, and all other parties of record in the board proceeding.

c. A party to the proceeding may file a resistance to the motion to amend within 14 days of the date of service of notice of the proposed amendment.

d. The board may grant a request to amend an application if it determines that the request serves the public interest.

263—7.7(368) Board proceedings on unanimous voluntary applications when no voluntary application or petition for involuntary annexation or incorporation of common territory is received within 30 days of the initial filing.

7.7(1) *Applicability.* If all territory included within the city's application is included upon application of the owner, by notice to the owner of railway right-of-way pursuant to Iowa Code section 368.7(1), or by notice to the Iowa attorney general or a county attorney pursuant to Iowa Code section 368.5, the application shall be processed pursuant to this rule.

7.7(2) *Initial board review.* The board shall review each request for approval of an application for voluntary annexation of territory within an urbanized area to determine compliance with the requirements of Iowa Code chapter 368 and these rules.

7.7(3) *Information considered.* The board shall provide any interested person or party an opportunity to submit written comment on the application prior to or at the time of board consideration of the request for approval. The board may:

a. Allow an opportunity for oral comment on the application;

b. Consider public documents; and

c. Request additional information from affected cities, counties or persons, including any of the information required to be included in a petition for involuntary city development action.

7.7(4) Criteria. The board may consider the criteria for approval of involuntary city development actions, as set forth in Iowa Code sections 368.16 and 368.17, in acting on an application for voluntary annexation.

7.7(5) If the request is found to be incomplete, the board may request further information from the applicant or the filing city or may dismiss the request, stating in its order the reason(s) for the dismissal.

7.7(6) If annexation of the territory is statutorily barred pursuant to Iowa Code section 368.17, the board shall deny the application, stating in its order the reason(s) for the denial.

7.7(7) If the board approves an application for voluntary annexation of territory within the urbanized area of another city, the board shall issue a written decision and file the decision with the clerk of the annexing city, other cities within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, the regional planning authority, each affected public utility, the state department of transportation, and all other parties of record in the board's proceeding. Upon expiration of the time for appeal, the board shall file with the secretary of state and record with the county recorder of each county containing a portion of the city or territory involved copies of the board's proceedings, as required by Iowa Code section 368.20(2).

7.7(8) If the board denies an application, it shall issue an order setting forth the reason(s) for the denial and shall provide a copy to the filing city.

263—7.8(368) Board proceedings on voluntary annexation requests which include land area without the consent of the landowner(s).

7.8(1) General rule. Territory comprising railway right-of-way or territory comprising not more than 20 percent of the land area may be included without the consent of the owner to avoid creating an island or to create more uniform boundaries.

7.8(2) Calculation of proportion of land area included without the consent of the owner(s).

a. Only contiguous land area may be considered for purposes of calculating the amount of the land area which may be included without the owner's consent.

b. The area of the territory that is public land included without the written consent of the agency with jurisdiction over the public land shall not be used to determine the percentage of territory that is included with the consent of the owner and without the consent of the owner.

7.8(3) Board action on proposal. The board shall review the request to determine compliance with the requirements of Iowa Code chapter 368 and these rules.

a. If the request is found to be incomplete, the board may request further information from the applicant or the filing city or may dismiss the request.

b. If the request is found to be in proper form and to contain all required information, the board will conduct a public hearing on the request, providing notice of the meeting by regular mail sent at least ten days prior to the hearing to all owners of land included in the annexation proposal, the annexing city, other cities within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, the regional planning authority containing a portion of the territory, each affected public utility, and the state department of transportation.

The board hearing shall be conducted informally. Representatives of the city requesting the annexation shall be given an opportunity to explain the proposal, the city's reason for including property without the consent of the owner(s), and any other information the city believes will assist the board in acting on the proposal. The county, all owners of property within the territory proposed for annexation, the regional planning authority, affected public utilities, and any other person affected by the annexation will be provided an opportunity to submit information to the board. The board may request additional information from the city, county or other persons, including any of the information required to be included in a petition for involuntary city development action.

c. The board shall consider whether the proposal serves the public interest and may consider the criteria for approval of involuntary city development actions, as set forth in Iowa Code sections 368.16 and 368.17, in acting on a request for voluntary annexation which includes the property of nonconsenting owners. The board may not approve a request for voluntary annexation of territory which includes the

property of nonconsenting owners unless the board finds that the land of the nonconsenting owners was included in order to (1) avoid creating an island, or (2) create more uniform boundaries.

d. A request for voluntary annexation of territory which includes the property of nonconsenting owners shall not be approved unless four members of the board vote in favor of the proposal.

e. If the board approves a request for voluntary annexation of territory which includes the property of nonconsenting owners, the board shall issue a written decision and file the decision with the clerk of the annexing city, other cities within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, the regional planning authority, each affected public utility, the state department of transportation, and any other party of record in the board proceeding. Upon expiration of the time for appeal, the board shall file with the secretary of state and record with the county recorder of each county containing a portion of the city or territory involved copies of the board's proceedings, as required by Iowa Code section 368.20(2).

f. If the board denies the request, an order shall be issued setting forth the reasons for the denial, and a copy shall be provided to the clerk of the annexing city, other cities within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, the regional planning authority, each affected public utility, the state department of transportation, and any other party of record in the board's proceeding.

[ARC 9278B, IAB 12/15/10, effective 1/19/11]

263—7.9(368) Board proceedings on voluntary applications when one or more voluntary applications or involuntary petitions for annexation of common territory are received within 30 days of the initial filing.

7.9(1) Initial board review. The board shall review the application(s) and petition(s) to determine compliance with the requirements of Iowa Code chapter 368 and these rules.

7.9(2) Dismissal. If an application or petition does not meet the requirements of Iowa Code chapter 368 or these rules, the board may dismiss the application or petition or request additional information from the applicant or petitioner. If only one application or petition remains before the board following such dismissal, the board will proceed on that filing as if no competing application or petition had been filed.

7.9(3) Hearing. If competing application(s) and petition(s) are found to be in proper form, the board will consider the voluntary application(s). The board may appoint a local committee pursuant to Iowa Code section 368.14 and shall conduct a public hearing pursuant to the procedure set forth in paragraph 7.8(3) "b" for hearings on voluntary applications including property without the consent of the owner(s).

7.9(4) Criteria for decision. Within 90 days of receipt of the application, the board or committee shall meet to assess the application and evidence received at the public hearing. If the application meets the applicable requirements of Iowa Code chapter 368, the board or committee shall approve the application unless the board makes one of the following findings by a preponderance of the evidence:

- a.* The application was filed in bad faith;
- b.* The application as filed is contrary to the best interests of the citizens of the urbanized area; or
- c.* The city that received the application cannot, within a reasonable period of time, meet its obligation to provide services to the territory to be annexed sufficient to meet the needs of the territory.

7.9(5) Decision if approved. If the board or committee approves a voluntary application considered under Iowa Code subsection 368.7(4), the board shall issue a written decision and file the decision with the clerk of the annexing city, other cities within two miles of the annexation territory, the board of supervisors of each county containing a portion of the territory, the regional planning authority, each affected public utility, the state department of transportation, and any other party to the board's proceeding. Upon expiration of the time for appeal, the board shall file with the secretary of state and record with the county recorder of each county containing a portion of the city or territory involved copies of the board's proceedings, as required by Iowa Code section 368.20(2).

7.9(6) Decision if statutorily barred. If annexation of the territory is statutorily barred under Iowa Code section 368.17, the board or committee shall deny the application, stating in its order the reason(s)

for the denial. An annexation request denied pursuant to this rule may not be converted to an involuntary petition, pursuant to subrule 7.9(7).

7.9(7) Action if not approved. If the application is not approved or is denied pursuant to subrule 7.9(6), the board shall issue an order setting forth its reason(s) for failing to approve the application and requiring conversion of the application into an involuntary petition. An application that contains some land without the consent of the owner to avoid the creation of an island or to create more uniform boundaries, that is considered by a committee, shall not be approved unless at least four of the board members and at least one-half of the local representatives vote in favor of the proposal. The city shall within 30 days withdraw its application or convert its application into an involuntary petition containing all information required to be included in such petitions by Iowa Code section 368.11 and these rules.

7.9(8) Following conversion of the application into an involuntary petition, the board shall order appointment of a special local committee to consider the application and all pending petitions for annexation of common territory, pursuant to Iowa Code section 368.14A. Committee appointments shall be made by resolution of the appropriate governing bodies within 45 days of issuance of the board's order. Each resolution shall state that the local representative selected is a qualified elector of the city or territory represented or, if none of the qualified electors of the territory will accept the appointment or the territory has no resident qualified electors, that the representative owns property within the territory. Copies of the resolutions shall be submitted to the board. In the event a city or county fails to timely notify the board of appointment of its local representative, the committee may conduct its proceedings in the absence of that local representative so long as a quorum is present.

7.9(9) The special local committee shall conduct a public hearing to receive evidence and comment on all applications and petitions pending before it. The order of presentation shall be determined by the committee prior to commencement of the hearing. The hearing shall be conducted in accordance with the rules for committee proceedings set forth in 263—Chapter 9.

7.9(10) The committee shall, within a reasonable time following conclusion of the public hearing, meet to determine appropriate means to resolve the common territory issues among the applications and petitions before it.

a. The committee shall resolve common territory issues by amending or denying one or more of the pending proposals.

b. Upon resolution of the common territory issues, the committee shall proceed with consideration of each remaining petition in accordance with Iowa Code sections 368.16 and 368.17 and these rules.

7.9(11) The committee shall issue a separate decision setting forth its findings and conclusions relating to each of the petitions. The committee shall file its decision with the board and promptly notify the parties of the decision, as required by Iowa Code section 368.19.

7.9(12) Upon receipt of a committee decision approving all or a portion of a petition, the board shall complete the procedural steps set forth within 263—Chapter 10.

263—7.10(368) Board proceedings on voluntary annexation applications containing common territory with a petition for involuntary annexation filed more than 30 days after the petition.

7.10(1) The board will receive the application and table action on it until processing of the petition is complete.

7.10(2) Same city. If the application proposes to annex territory to the same city filing the petition, the board may proceed on the application under rule 7.7(368).

263—7.11(368) Costs. The cost of recording the board order, if the annexation is approved, shall be borne by the city to which territory is annexed.

263—7.12(368) Board proceedings on boundary adjustments between cities by petition and consent.

7.12(1) General rule. A request for board approval to sever real property from one city and to annex the same real property to another city shall be initiated pursuant to 2010 Iowa Acts, House File 2376. Contiguous property may be combined within the same request.

7.12(2) Contents of petition. The petition under this rule shall be in substantially the same form as an application under Iowa Code section 368.7 and rule 263—7.2(368). Additionally, if the city council of either city conditioned approval of the petition upon an agreement entered into by the cities providing for the transition of property taxes or the sharing of property tax revenues from the property described in the petition, the agreement shall be filed with the board at the same time the approved petition is filed.

7.12(3) Initial board review. The board shall review each petition to sever real property from one city and to annex the same real property to another city in order to determine compliance with the requirements of Iowa Code section 368.7 and these rules. The board shall notify both cities and the real property owner(s) of the board's initial review of the severance and annexation petition. If the petition does not meet the requirements of Iowa Code section 368.7, the board may request additional information before making a final decision or may dismiss the petition. If the application is found to be in proper form, the board shall hold a public hearing on the severance, annexation, and any agreement between the cities.

7.12(4) Public hearing. The board shall give notice of the public hearing in the same manner as notice of a public meeting under Iowa Code section 368.11, subsection 5. The board shall conduct a public hearing pursuant to the procedure set forth in paragraph 7.8(3) "b" for hearings on voluntary applications.

7.12(5) Decision criteria. The board shall consider whether the request serves the public interest and may consider the criteria for approval of involuntary city development actions as set forth in Iowa Code sections 368.16 and 368.17. The board may approve or deny only the severance and annexation of the real property described in the petition. The board may approve the petition only if the board also approves any agreement entered into by the cities pursuant to 2010 Iowa Acts, House File 2376. The board shall not approve the petition if the severance and annexation creates an island.

7.12(6) Denial. If a petition is denied, the board shall issue an explanation for the denial. A copy of the explanation shall be provided to the clerk of each city involved in the severance and annexation and to any other party of record in the board's proceeding.

7.12(7) Approval. If a petition is approved, the board's order approving the severance and annexation is not subject to approval at an election. The board shall file and provide a copy of the order to the clerk of each city involved in the severance and annexation, the recorder of each county that contains a portion of any city or territory affected by the severance and annexation, and any other party of record in the board's proceeding. Upon expiration of the time for appeal, the board shall file with the Iowa secretary of state and record with the recorder of each county that contains a portion of any city or territory involved copies of the proceedings, including the petition, any agreement between the cities, the board's order approving the petition, proof of service and publication of required notices, and any other material deemed by the board to be of primary importance to the proceeding. The board shall file a map and legal description with the Iowa department of transportation.

[ARC 9278B, IAB 12/15/10, effective 1/19/11]

These rules are intended to implement Iowa Code section 368.7.

[Filed 11/20/02, Notice 7/10/02—published 12/11/02, effective 1/15/03]

[Filed ARC 9278B (Notice ARC 9106B, IAB 9/22/10), IAB 12/15/10, effective 1/19/11]

[Filed ARC 9546B (Notice ARC 9438B, IAB 3/23/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 8
PETITIONS FOR INVOLUNTARY CITY DEVELOPMENT ACTION
[Prior to 12/11/02, see 263—Ch 2]

263—8.1(368) Board and committee action required. All petitions filed pursuant to Iowa Code section 368.11 requesting involuntary city development action, including incorporation, discontinuance, annexation, severance, or consolidation, must be reviewed by the city development board and, if in proper form, acted upon by a local committee established pursuant to Iowa Code section 368.14 or 368.14A.

263—8.2(368) Initiation of petition. A petition for involuntary city development action may be initiated, pursuant to Iowa Code sections 368.11 and 368.13, by a city council, a county board of supervisors, a regional planning authority, 5 percent of the qualified electors of a city or territory involved in the proposal, or the city development board. When a proposal for city development action is initiated by the city development board, the board may require a city to submit a petition or may formulate its own petition.

263—8.3(368) Contents of the petition. The body or bodies initiating the petition shall be known as the petitioner(s). The petition shall be prefaced by an introductory statement in the following general form:

We, the [city council of _____] [county board of supervisors of _____ county] [regional planning authority for _____] [certain qualified electors of _____] do hereby petition the city development board of the state of Iowa for an [incorporation] [discontinuance] [boundary change], more specifically described as [description of proposed action], and involving land described as [complete legal description].

In addition, the petition shall contain the following information, as required by Iowa Code section 368.11:

8.3(1) General statement of proposal. The general statement of proposal shall be an overview of the proposal, briefly describing the characteristics of the city and territory and the reasons for the corporate boundary change.

8.3(2) Moratorium. The petition shall contain a statement indicating whether a territory proposed for annexation is subject to an existing moratorium agreement and, if so, whether the proposed annexation is consistent with the terms of the agreement.

8.3(3) Map. The map shall clearly show all boundaries of the city and the entire annexation territory, adjacent roadways, the relationship of the territory to the city, and all geographic features deemed relevant to the proposed action. In cases of incorporation, a map of the proposed city boundary shall be provided. In cases of discontinuance or consolidation, a map of the existing city or cities shall be provided. Where land use patterns are expected to be pertinent to consideration of the proposal, the petitioner may be requested to present graphic material representing existing and anticipated use of the territory.

8.3(4) Legal description. The petition shall include a complete legal description of the territory proposed for annexation, severance, incorporation, discontinuance, or consolidation. In cases of annexation, the description of the right-of-way of secondary roads, included as required by Iowa Code section 368.1(14), shall be provided. Prior to filing the petition, the city shall provide a copy of the legal description, map of the territory and list of property owners identified by the city to the county auditor, including the right-of-way of secondary roads, which is included as required by Iowa Code section 368.1(14), with a request that the auditor verify the accuracy and completeness of the legal description and verify current ownership of the parcel(s) involved. The auditor's response shall be included in the petition. If the auditor fails to respond to the request within 14 days, the city may provide a copy of the request and a statement indicating that no response was received in lieu of the auditor's verification.

8.3(5) Assessed valuations. The assessed valuation and classification assigned for tax purposes (agricultural, residential, commercial, etc.) for each parcel of platted and unplatted land within the territory shall be included. This information shall be verified in writing by the city or county assessor. If

upon request by the city, the assessor fails to provide verification of this information within 14 days, the city may provide a copy of the request and a statement indicating that the verification was not provided by the assessor in lieu of the assessor's verification.

8.3(6) Property owners. The name and address of each owner of property within the territory.

8.3(7) Population density. Population density in terms of persons per acre for annexation or persons per square mile for incorporation, discontinuance, severance or consolidation. Population density shall be delineated for the existing city, the territory, and for the resulting city if the proposal is approved.

8.3(8) Potential growth in population. If the petition seeks annexation, consolidation or incorporation, projected population growth for the city and the territory shall be provided. Population projections shall be for a 10- or 20-year period and may be taken from an existing comprehensive plan or may be calculated based on relevant data if no comprehensive plan exists.

8.3(9) Residential and commercial development regulation and projections. The petition shall include a description of current and proposed zoning regulations that apply to the annexation territory. Projected development and land use patterns shall be described under the assumption of continuation of existing land use regulations and under the assumption of land use regulations that would be applied after the annexation, if approved. Residential, commercial, and industrial development projections shall be provided based on population projections for the city and territory.

In the case of annexation, the amount of vacant developable land within the existing corporate limits and within the territory, as well as an estimate of the amount of developable land needed to accommodate future growth, shall be provided. Petitions for annexation shall include a statement indicating whether the city has applied smart planning principles to the territory and, if applicable, a description of how the city has applied, or intends to apply, smart planning principles.

8.3(10) Description of topography. Topographical information shall be in map and narrative form. Maps shall include both the city and territory and shall consist of contour lines at ten-foot intervals as may be taken from contour maps of the United States Geological Survey or any other source acceptable to the board. A narrative description of the area's topography shall accompany the maps and identify flood plains, drainage areas, drainage ways, slopes and bluffs. In petitions seeking annexation or incorporation, the narrative shall also address topography as it relates to development of urban uses and the extension of municipal services.

8.3(11) Plans for disposal of assets, assumption of liabilities, and provision of services including the following information:

a. Petitions for annexation, consolidation and incorporation shall include a description of existing municipal services and facilities, including but not limited to water supply, sewage disposal, police and fire protection, and street and road maintenance. The petition shall also include information regarding the city's proposal for providing municipal services, including but not limited to water supply, sewage disposal, street and road maintenance, and police and fire protection to the territory, proposed new city, or consolidated city, and the estimated cost of providing said services.

b. In cases of annexation, the petition shall include a statement of the capability of the existing city sewage system, water system, transportation infrastructure, park and recreation system, and police, fire, and public works departments to accommodate the increased demand resulting from addition of the territory to the city and the demand which will result from projected development in the territory. The petition shall also include an analysis of existing bonding capacity and bonded indebtedness, and the assets the city may receive that will offset the cost of providing municipal services, including property tax, increase in municipal bonding capacity, state and federal shared revenues, special assessment policies, revenue bonds, user fees, and federal funds where applicable.

c. In cases of incorporation, a statement of the capability of the proposed city to develop a sewage system, water system, transportation infrastructure, park and recreation system, and police, fire, and public works departments to accommodate the territory proposed for incorporation, and an explanation of the assets the proposed city may receive that will offset the cost of providing municipal services, including property tax, increase in municipal bonding capacity, state and federal shared revenues, special assessment policies, revenue bonds, user fees, and federal funds where applicable.

d. Petitions for severance and discontinuance shall include a statement of the adequacy of sewage disposal, water supply, police and fire protection, and other municipal services being provided to the territory by the city; a statement of the capability and intent of the county in which the city or territory is located to assume responsibility for police protection, street and road maintenance and repair, and other services; and an analysis of the capability of the township fire district to provide fire protection.

e. Petitions for discontinuance shall include an inventory of all real estate, funds, and personal property owned by the city and all existing liabilities of the city, and a proposal for disposition of all assets and satisfaction or assumption of all liabilities.

8.3(12) Effect of the proposal and possible alternative proposals. At a minimum, the petition shall include a description of the effect that approval of the proposal will have on the cost and adequacy of services and facilities and a description of the effect of disapproval of the proposal on the cost and adequacy of services and facilities.

8.3(13) Effect of proposal on adjacent areas. The petition shall include documentation of the amount of revenue lost or gained by any city, township, or county affected by the proposal. Consideration shall be given to property tax, state shared revenues, federal revenue sharing, and any other major sources of revenue.

8.3(14) Service agreements. The petition shall identify services which may be provided through agreement with township fire districts, rural water and sanitary districts, and proposed agreements with any county or city for police protection, ambulance service, or any other service deemed to be of importance to the proposed boundary adjustment and shall present examples of existing service agreements.

8.3(15) Shared roads. The petition shall include a proposed formal agreement between affected municipal corporations and counties for the maintenance and improvement and traffic control of any road that is divided as a result of an incorporation or a boundary adjustment.

8.3(16) Name of proposed city. A petition for incorporation or consolidation shall state the name of the proposed resulting city.

8.3(17) Transition of taxation. In cases of annexation the city may, but is not required to, include a provision for transition for the imposition of city taxes against property within the annexation territory. The provision shall not allow greater exemption for taxation than the tax exemption formula schedule provided under Iowa Code section 427B.3, subsections 1 through 5, and shall be applied in the levy and collection of taxes. The provision may also allow for the partial provision of city services during the time in which the exemption from taxation is in effect.

8.3(18) Islands. The petition shall state whether approval of the proposal will create an island of unincorporated area.

8.3(19) Location of the territory. Petitions for annexation, incorporation, and consolidation shall include the following information:

a. Annexation. Petitions for annexation shall state whether the territory is adjoining the city to which annexation is proposed and whether any of the territory is in an existing city.

b. Incorporation. Petitions for incorporation shall state whether any of the territory to be incorporated is in an existing city or within two miles of the boundary of an existing city. If all or a portion of the area proposed for incorporation is within two miles of another city, the petition must include documentation that a petition for annexation of substantially the same territory has been dismissed, disapproved, or voted upon unfavorably within five years prior to filing of the petition.

c. Consolidation. Petitions for consolidation shall state whether all of the affected cities are contiguous.

[ARC 9546B, IAB 6/1/11, effective 7/6/11]

263—8.4(368) Preliminary notice and public meeting. A petitioner initiating an involuntary city development proceeding shall comply with the applicable notice, publication, and public meeting requirements contained in Iowa Code section 368.11. For purposes of calculating the required period of notice, “business days” shall include Monday through Friday of each week, excluding “legal holidays” as set forth in Iowa Code section 4.1(34). Proof of substantial compliance with these requirements,

including copies of certified mail receipts, certification of publication of notice of the meeting, minutes of the public meeting and copies of the documents received at the meeting, shall accompany each petition for involuntary city development action filed with the board.

263—8.5(368) Filing and service.

8.5(1) Filing. The original and 15 copies of a petition shall be filed with the board. A petition will be deemed filed with the board on the date it is received by board staff. The board shall return a file-stamped copy of the petition to the petitioner.

8.5(2) Service. Within seven days of the filing of a petition with the board the petitioner shall serve notice of the filing, including a copy of the petition, upon the council of each city for which a discontinuance, annexation, severance or consolidation is proposed; the board of supervisors for each county which contains a portion of a city to be discontinued or territory to be incorporated, annexed, or severed; and the regional planning authority for the area involved.

8.5(3) Proof of service. The petitioner shall file proof of compliance with the service requirement of subrule 8.5(2) with the board.

263—8.6(368) Costs. All costs which are incurred in drafting a petition, preparing supporting documents, mailing and publishing notices and other preliminary proceedings and the cost of recording, if the proposal is approved, shall be borne by the petitioner(s).

263—8.7(368) Staff review of petition. Within two weeks of the filing of a petition for involuntary city development action, board staff shall review the request to determine whether the city has filed all of the information required by rule 8.3(368). If the request is found to be incomplete, staff shall notify the petitioner, identifying the required item(s) omitted and offering the petitioner an opportunity to provide the omitted information prior to submission of the petition to the board.

263—8.8(368) Submission of petition to the board—notice. Petitions will be submitted to the board at the first meeting conducted 31 days or more after filing of the petition. The board shall provide the petitioner with notice of all meetings at which the board will consider or act upon the petition.

263—8.9(368) Board review of petition. Upon submission of a petition, the board shall review the petition for substantial compliance with Iowa Code section 368.11 and rules 8.3(368) through 8.5(368). In conducting this review, the board will presume that factual assertions made within the petition are accurate. The board may, however, request and examine appropriate public records or request additional information from the petitioner if deemed necessary to its review.

The board may waive any requirement of these rules upon finding the requirement inapplicable to the petition under review.

263—8.10(368) Board action on petition. On the basis of its review of the petition, the board shall accept the petition for further proceedings or dismiss the petition.

8.10(1) Acceptance. The board shall accept for further proceedings any petition that it finds to be in substantial compliance with the filing requirements of Iowa Code section 368.11 and these rules and not subject to dismissal pursuant to Iowa Code section 368.12.

8.10(2) Dismissal. A petition may be dismissed by the board only upon finding one of the statutory grounds for dismissal set forth in Iowa Code section 368.12. In cases of dismissal, the board shall issue an order indicating the reasons for the dismissal, providing copies to the petitioner and all parties to the proceeding.

263—8.11(368) Formation of local committee. If the petition is accepted by the board for further proceedings, the board shall direct the appointment of local representatives to serve with the board as a city development committee as required by Iowa Code section 368.14. Committee appointments shall be made by resolutions of the appropriate governing bodies within 45 days of issuance of the board's order. The resolutions shall state that the local representative selected is a qualified elector

of the city or territory represented or, if none of the qualified electors of the territory will accept the appointment or the territory has no resident qualified electors, that the representative owns property within the territory. Copies of the resolutions and the address and telephone number of each local representative shall be promptly submitted to the board. In the event a city or county fails to timely notify the board of appointment of its local representative, the committee may conduct its proceedings in the absence of that local representative so long as a quorum is present.

These rules are intended to implement Iowa Code chapter 368.

[Filed 8/16/73, amended 9/12/73, 11/13/74]

[Filed 10/29/75, Notice 7/14/75—published 11/17/75, effective 12/22/75]

[Filed 7/5/77, Notice 5/18/77—published 7/27/77, effective 8/31/77]

[Filed 2/16/78, Notice 1/11/78—published 3/8/78, effective 4/12/78]

[Filed emergency 3/2/79—published 3/21/79, effective 3/2/79]

[Filed 12/19/90, Notice 10/17/90—published 1/9/91, effective 2/13/91]

[Filed 11/20/02, Notice 7/10/02—published 12/11/02, effective 1/15/03]

[Filed ARC 9546B (Notice ARC 9438B, IAB 3/23/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Effective July 1, 2009, providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) “e”(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) “aa” and 79.1(16) “h.”

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above. Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or \$21.57 per half-day, \$42.93 per full day, or \$64.38 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, in the absence of a contract rate, \$28.73 per half-day, \$57.36 per full day, or \$73.13 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Initial one-time fee: \$48.29. Ongoing monthly fee: \$37.56.
Portable locator system	Fee schedule	One equipment purchase: \$300. Initial one-time fee: \$48.29. Ongoing monthly fee: \$37.56.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of \$19.31 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver: \$80.85 per visit. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed \$80.85 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed \$296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$32.91 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	\$17.56 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$32.91 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	\$17.56 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	\$12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	\$12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	\$12.79 per hour not to exceed \$296.94 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Adult day care	Fee schedule	\$12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	\$12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	\$12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	\$12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	\$12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	\$7.52 per half hour.
8. Home-delivered meals	Fee schedule	\$7.52 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule	For elderly waiver: \$1,010 lifetime maximum. For intellectual disability waiver: \$5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: \$6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	\$8.04 per unit.
13. Assistive devices	Fee schedule	\$107.30 per unit.
14. Senior companion	Fee schedule	\$6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	\$19.70 per hour not to exceed the daily rate of \$113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	For elderly waiver only: \$1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed \$35.79 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, \$13.47 per hour not to exceed the daily rate of \$78.56 per day.
16. Counseling		
Individual:	Fee schedule	\$10.52 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Group:	Fee schedule	\$42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)“d.”	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	\$34.11 per hour, \$76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.11 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of \$19.31 per hour for personal care. Maximum of \$6.04 per hour for services in an enclave setting. Total not to exceed \$2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	\$6,060 per year.
21. Behavioral programming	Fee schedule	\$10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	\$42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: \$47.01 per day, \$23.51 per half day, or \$12.88 per hour. For the intellectual disability waiver: County contract rate or, in absence of a contract rate, \$47.01 per day, \$23.51 per half day, or \$12.88 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	\$12.79 per hour.
Supported community living provider	Retrospectively limited prospective rate	\$34.11 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, \$12.88 per hour, \$31.35 per half-day, or \$62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	\$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	\$34.11 per hour.
29. In-home family therapy	Fee schedule	\$91.29 per hour.
30. Financial management services	Fee schedule	\$64.01 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	\$14.77 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour or \$105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“2” is 96% of the patient-day-	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) "a"	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	\$4.34 dispensing fee. (See 79.1(8) "a," "b," and "e.")
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)“d.”	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) Reimbursement for hospitals.

a. Definitions.

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

“Average daily rate” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“Base year cost report” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base amount” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted

operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

“Diagnosis-related group (DRG)” shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rate table listing*” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“*Rebasing*” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“*Rebasing implementation year*” means 2008 and every three years thereafter.

“*Recalibration*” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“*Short stay day outlier*” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)“f.”

b. *Determination of final payment rate amount.* The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)“r.” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)“r.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. *Calculation of Iowa-specific weights and case-mix index.* From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals

during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)“r,” both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base

and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph "y."

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)“i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) “y” and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department’s total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)“y” and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department’s total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department’s total year-end disproportionate share obligation shall not exceed the difference between \$51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under

the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage

shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)“u” or 79.1(5)“v” cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children’s hospital. A licensed hospital qualifies for disproportionate share payments as a children’s hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children’s Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children’s hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.
3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid Enterprise shall complete a final settlement based on the hospital’s Medicare cost report. If the aggregate payments are less than the hospital’s actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)“a” to “z” are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital’s annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)“a” to “z.” Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)“k.”

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph “g.”

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph “g.”

(4) The submitted charge, representing the provider’s usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”

(2) The submitted charge, representing the provider’s usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph “a” except that the department shall establish a maximum allowable reimbursable cost for these drugs

using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after July 1, 2010, the professional dispensing fee is \$4.34 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8) "a"(3) and 79.1(8) "c" and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13) "b," 78.37(16) "b," 78.38(9) "b," 78.41(15) "b," 78.43(15) "b," or 78.46(6) "b."

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) Prohibition against reassignment of claims. No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a

condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph “e.”

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph “d.”

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider’s new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph “f.”

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph “f.”

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider’s reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services rendered July 1, 2010, through June 30, 2011, revenues exceeding 100 percent of adjusted actual costs shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 100 percent of actual costs 30 days after notice is given by the department will have the revenues over 100 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer’s needs, or if there is a subsequent change in the consumers at a site or in any consumer’s needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer’s needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site’s average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

“Allowable costs” means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

“Ambulatory payment classification” or *“APC”* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

“Ambulatory payment classification relative weight” or *“APC relative weight”* means the relative value assigned to each APC.

“Ancillary service” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“APC service” means a service that is priced and paid using the APC system.

“Base year cost report,” for rates effective January 1, 2009, means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base APC rate” shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

“Case-mix index” shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“Cost outlier” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“Current procedural terminology—fourth edition (CPT-4)” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“Diagnostic service” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“*International classifications of diseases—fourth edition, ninth revision (ICD-9)*” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“*Multiple significant procedure discounting*” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“*Observation services*” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“*Outpatient hospital services*” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. *Outpatient hospital services.* Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital

elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

G	Pass-through drugs and biologicals	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	Pass-through device categories	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	Influenza vaccine Pneumococcal pneumonia vaccine	<p>If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	Items and services not billable to the Medicare fiscal intermediary	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	<p>Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.</p>
P	Partial hospitalization	<p>Not a covered service under Iowa Medicaid.</p>
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” • In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>

Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
---	--	---

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n."

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n," for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPSS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)“v”(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal

match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid Enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicaid-allowed amount*” means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicaid reimbursement*” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant

to paragraph “b” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “b.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)“d.” Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment

is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) Effective July 1, 2009, a unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24) "b," the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled into the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

- b.* Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.
- c.* Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
- d.* Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.
- e.* Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.
- f.* Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.
- g.* Failure to comply with the terms of the provider certification on each medical assistance check endorsement.
- h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.
- i.* Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.
- j.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.
- k.* Submission of a false or fraudulent application for provider status under the medical assistance program.
- l.* Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.
- m.* Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.
- n.* Failure to meet standards required by state or federal law for participation, for example, licensure.
- o.* Exclusion from Medicare because of fraudulent or abusive practices.
- p.* Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.
- q.* Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.
- r.* Formal reprimand or censure by an association of the provider's peers for unethical practices.
- s.* Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.
- t.* Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) Sanctions. The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

- a.* A term of probation for participation in the medical assistance program.
- b.* Termination from participation in the medical assistance program.
- c.* Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.
- d.* Suspension or withholding of payments to provider.
- e.* Referral to peer review.
- f.* Prior authorization of services.
- g.* One hundred percent review of the provider's claims prior to payment.
- h.* Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- (1) Seriousness of the offense.
- (2) Extent of violations.
- (3) History of prior violations.
- (4) Prior imposition of sanctions.
- (5) Prior provision of provider education.
- (6) Provider willingness to obey program rules.
- (7) Whether a lesser sanction will be sufficient to remedy the problem.
- (8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)"c" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

- a.* The nature of the discrepancies or violations,
- b.* The known dollar value of the discrepancies or violations,
- c.* The method of computing the dollar value,
- d.* Notification of further actions to be taken or sanctions to be imposed by the department, and
- e.* Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) Suspension or withholding of payments pending a final determination. Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. *Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.

9. Progress or status notes for the services or activities provided.
 10. All forms required by the department as a condition of payment for the services provided.
 11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
 12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
 13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.
- (3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:
1. The specific procedures or treatments performed.
 2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
 3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
 4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,” 441—paragraph 77.33(6)“d,” 441—paragraph 77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
 5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
 6. Any supplies dispensed as part of the service.
 7. The first and last name and professional credentials, if any, of the person providing the service.
 8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
 9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.

- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.

- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.

- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.

- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.
 4. Prior authorization documentation.
 5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 - e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.
 - (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative*,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
 Reviewer Name & Phone Number: _____
 Provider Name: _____
 Provider Number: _____
 Provider Type: _____

Please sign this form and return it with the information requested. Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
-----------	-------	------------------

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider’s designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department’s denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department’s employee or authorized agent may give as little as one day’s advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. *Use of statistical sampling techniques.* The department’s procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph “a” of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting.

Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

- (1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or
- (2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children’s hospital, defined as a separately certified children’s hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider’s application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa

Medicaid portal access (IMPA) Web site at <https://secureapp.dhs.state.ia.us/impa/>. The applicant shall use the Web site to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a.* Provider eligibility determination.
- b.* Incentive payments.
- c.* Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11]

[Filed March 11, 1970]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]

[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]

[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]

[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]

[Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]

[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]

[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]

[Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]

[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]

[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]

[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]

[Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]

[Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]

[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]

- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
- [Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]
- [Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
- [Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
- [Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
- [Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88¹]
- [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88][◇]
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
- [Filed 12/22/88, Notices 11/16/88[◇]—published 1/11/89, effective 3/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]

- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90²]
- [Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
- [Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
- [Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
- [Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notices 7/11/90⁰—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91³]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92⁴]
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
- [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
- [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
- [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
- [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]
- [Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]

- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94]◊
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]
- [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]◊
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
- [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
- [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]
- [Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
- [Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]

- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
 - [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
 - [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
 - [Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
 - [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◇
 - [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
 - [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
 - [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
 - [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]◇
 - [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
 - [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02⁵]
 - [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
 - [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
 - [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
 - [Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
 - [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02⁶]
 - [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
 - [Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]
 - [Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]
 - [Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
 - [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
 - [Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
 - [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
 - [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]◇
 - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]◇
 - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◇
 - [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
 - [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
 - [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]◇
 - [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
 - [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]◇
 - [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
 - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
 - [Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]
 - [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]◇
 - [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]
 - [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
 - [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
 - [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
 - [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
 - [Filed 6/16/06, Notice 4/26/06—published 7/5/06, effective 9/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
 - [Filed 8/10/06, Notice 2/15/06—published 8/30/06, effective 11/1/06]
 - [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
 - [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]

- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
 [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
 [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
 [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
 [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
 [Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
 [Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
 [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
 [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
 [Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]
 [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
 [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
 [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
 [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
 [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
 [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
 [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
 [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
 [Filed ARC 7835B (Notice ARC 7627B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
 [Filed Emergency ARC 7937B, IAB 7/1/09, effective 7/1/09]
 [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]⁷
 [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
 [Filed ARC 8206B (Notice ARC 7938B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]
 [Filed ARC 8262B (Notice ARC 8084B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
 [Filed ARC 8263B (Notice ARC 8059B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
 [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
 [Filed Emergency ARC 8647B, IAB 4/7/10, effective 3/11/10]
 [Filed Emergency ARC 8649B, IAB 4/7/10, effective 3/11/10]
 [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
 [Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
 [Filed Emergency ARC 8899B, IAB 6/30/10, effective 7/1/10]
 [Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
 [Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]
 [Filed Emergency ARC 9134B, IAB 10/6/10, effective 10/1/10]
 [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
 [Filed ARC 9176B (Notice ARC 8900B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]
 [Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
 [Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
 [Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]
 [Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
 [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
 [Filed Emergency After Notice ARC 9531B (Notice ARC 9431B, IAB 3/23/11), IAB 6/1/11, effective 5/12/11]

⁰ Two or more ARCs

¹ Effective date of 79.1(2) and 79.1(5)“t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

- ³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 92 IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code section 249J.6.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1) "b."

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care

are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) Persons covered. Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph “*b.*”

92.2(2) Citizenship. To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) Other disqualification. A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) Group health insurance. A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member’s group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) Payment of assessed premiums. IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

92.2(6) Availability of funds. Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

[ARC 8505B, IAB 2/10/10, effective 4/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department’s request.

92.3(2) A new application is required for each certification period.
[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) Verification. Applicants seeking eligibility under 92.2(1)“b” shall provide verification of medical expenses as required under 92.5(5)“b.” IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

c. If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

92.4(2) Screening for full Medicaid. The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) Time limit for decision. The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

[ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant’s household as of the date of decision. To be eligible, the household’s income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) Household size. The household size shall include the applicant and the applicant’s dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant’s spouse shall not be considered absent from the home when:

(1) The spouse’s absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)“b” shall be applied to determine whether a person’s absence is temporary.

92.5(2) Self-declaration of income. Applicants shall self-declare the household’s future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household’s monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) Earned income. All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1) “*b*”(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3) “*b.*”

92.5(4) Unearned income. Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph “*b,*” “*c,*” “*d,*” “*e,*” “*f,*” “*g,*” “*h,*” “*i,*” “*j,*” “*k,*” “*l,*” “*m,*” “*p,*” “*q,*” “*r,*” “*t,*” “*u,*” “*v,*” “*w,*” “*x,*” “*y,*” “*z,*” or “*aa*”; or

b. 441—subrule 75.57(7), paragraph “*a,*” “*b,*” “*c,*” “*d,*” “*e,*” “*f,*” “*g,*” “*h,*” “*i,*” “*j,*” “*k,*” “*l,*” “*m,*” or “*q.*”

92.5(5) Deductions. The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1) “*b,*” medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

- (1) Health insurance premiums, deductibles, or coinsurance charges; and
- (2) Medical and dental expenses.

92.5(6) Disregard of changes. A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) Unearned nonrecurring lump-sum income. All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) Earned lump-sum income. Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) Certification period. IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

a. For women and newborns eligible under 92.2(1) “*b*” or “*c,*” the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

92.6(4) *Reinstatement.* Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1) “c” and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium is based on the household’s countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Effective for applications and recertifications received on or after June 1, 2011, premiums are as follows:

When there is one IowaCare member in the household and the household’s income is at or below:	The member’s premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$50
170% of federal poverty level	\$54
180% of federal poverty level	\$57
190% of federal poverty level	\$60
200% of federal poverty level	\$63

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$68
170% of federal poverty level	\$72
180% of federal poverty level	\$77
190% of federal poverty level	\$81
200% of federal poverty level	\$85

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) Billing and payment. Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. Due date. When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) Hardship exemption. A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph “*c.*” If the statement is not postmarked by the premium due date, the member or household shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) Failure to pay premium. If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) Refund of premium. When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph "a," premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

- (1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);
- (2) Has access to group health insurance coverage as defined in subrule 92.2(4);
- (3) Reaches age 65;
- (4) Dies; or
- (5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

- (1) Two calendar months after eligibility ended unless an application or reapplication is pending,

or

- (2) Upon the person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

- (1) After two calendar months of a zero premium, or
- (2) Upon the member's request.

[ARC 7667B, IAB 4/8/09, effective 4/1/09; ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9532B, IAB 6/1/11, effective 7/6/11]

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) Provider network. Except as provided in subrules 92.8(3) through 92.8(6), IowaCare members shall have medical assistance only for services provided to the member by:

- a. The University of Iowa Hospitals and Clinics; or
- b. Broadlawns Medical Center in Des Moines; or

c. A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

92.8(2) Covered services. Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1) “b” or “c” are also eligible for the services specified in paragraph “a” or “b” from the providers specified in paragraph “c” or “d.”

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1) “b” or “c” and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1) “c.” Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

92.8(6) *Medical home.* As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

- (4) Provide wellness and disease prevention services.
- (5) Create and maintain chronic disease information in a searchable disease registry.
- (6) Demonstrate evidence of implementation of an electronic health record system.
- (7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall enroll the member with that provider. A member who is enrolled with a medical home provider:

- (1) Shall utilize the medical home provider for covered services available from that provider, and
- (2) Must receive a referral from the medical home provider to another IowaCare provider for any services not available from the medical home provider.

92.8(7) *Emergency services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

- (1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.
- (2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.
- (3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.
- (4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.
- (5) The treating nonparticipating provider has consulted with the IowaCare provider network hospital and the providers jointly agree that the conditions for payment are met.
- (6) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services and documentation of the consultation with the IowaCare network provider.

b. If the conditions listed in paragraph “a” are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) *Claims.* Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) *Payment for hospital services provided by IowaCare network.* Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

- (1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.
- (2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital’s CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital’s cost report. For purposes of this rule, aggregate payments include amounts received

for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) *Payment for nonhospital services provided by IowaCare network.* Effective July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Physician services provided to IowaCare members in a federally qualified health center shall be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) *Medical home payments.*

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than \$4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) *Payment for services provided by nonparticipating hospitals.* Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) *Payment for services provided by other nonparticipating providers.* Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
- b. The certification has expired.

441—92.11(249A,249J) *Reapplication.* A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3) "a" or "b" applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) *Terminating eligibility.* IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) *Recovery.* The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.14(249A,249J) *Discontinuance of the program.* IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]

[Filed emergency 7/15/05—published 8/3/05, effective 7/15/05]

[Filed 12/14/05, Notices 7/6/05, 8/3/05—published 1/4/06, effective 3/1/06]

[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]

[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 10/1/06]

[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]

[Filed emergency 3/14/07—published 4/11/07, effective 4/1/07]

[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]

[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]

[Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]

[Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]

[Filed 10/10/07, Notice 8/1/07—published 11/7/07, effective 1/1/08]

[Filed emergency 4/9/08—published 5/7/08, effective 4/9/08]

[Filed emergency 6/11/08 after Notice 3/12/08 —published 7/2/08, effective 7/1/08]

[Filed emergency 6/12/08 after Notice 4/23/08—published 7/2/08, effective 7/1/08]

[Filed emergency 7/9/08 after Notice 5/21/08—published 7/30/08, effective 8/1/08]

[Filed Emergency ARC 7667B, IAB 4/8/09, effective 4/1/09]

[Filed ARC 8505B (Notice ARC 8256B, IAB 11/4/09), IAB 2/10/10, effective 4/1/10]

[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10,
effective 3/1/10]

[Filed Emergency After Notice ARC 9135B (Notice ARC 8977B, IAB 7/28/10), IAB 10/6/10,
effective 10/1/10]

[Filed Without Notice ARC 9532B, IAB 6/1/11, effective 7/6/11]

NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571]
under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

TITLE I *GENERAL*

CHAPTER 1

OPERATION OF NATURAL RESOURCE COMMISSION

- | | |
|----------------|--|
| 1.1(17A,455A) | Scope |
| 1.2(17A,455A) | Time of meetings |
| 1.3(17A,455A) | Place of meetings |
| 1.4(17A,455A) | Notification of meetings |
| 1.5(17A,455A) | Attendance and participation by the public |
| 1.6(17A,455A) | Quorum and voting requirements |
| 1.7(17A,455A) | Conduct of meeting |
| 1.8(17A,455A) | Minutes, transcripts, and recordings of meetings |
| 1.9(17A,455A) | Officers and duties |
| 1.10(17A,455A) | Election and succession of officers |
| 1.11(68B) | Sales of goods and services |

CHAPTER 2

PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

- | | |
|---------|-----------------------|
| 2.1(22) | Adoption by reference |
|---------|-----------------------|

CHAPTER 3

SUBMISSION OF INFORMATION AND COMPLAINTS—INVESTIGATIONS

- | | |
|----------|-----------------------|
| 3.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 4

AGENCY PROCEDURE FOR RULE MAKING

- | | |
|----------|-----------------------|
| 4.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 5

PETITIONS FOR RULE MAKING

- | | |
|----------|-----------------------|
| 5.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 6

DECLARATORY RULINGS

- | | |
|----------|-----------------------|
| 6.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 7

RULES OF PRACTICE IN CONTESTED CASES

- | | |
|----------|-----------------------|
| 7.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 8

CONTRACTS FOR PUBLIC IMPROVEMENTS AND PROFESSIONAL SERVICES

- | | |
|----------|-----------------------|
| 8.1(17A) | Adoption by reference |
|----------|-----------------------|

CHAPTER 9

STATE MIGRATORY WATERFOWL, TROUT AND HABITAT STAMP DESIGN CONTESTS

- | | |
|----------------|-------------------------------|
| 9.1(483A,484A) | Design contests |
| 9.2(483A,484A) | Selection of promoter |
| 9.3(483A,484A) | Stamp design—related proceeds |

- 9.4(483A,484A) Design
- 9.5(483A,484A) Commissioned design
- 9.6(483A,484A) Financial records
- 9.7(483A,484A) Title to property

CHAPTER 10
FORFEITED PROPERTY

- 10.1(809) Purpose
- 10.2(809) Definitions
- 10.3(809) Jurisdiction
- 10.4(809) Supervisor approval
- 10.5(809) Disposition of general property
- 10.6(809) Disposition of weapons
- 10.7(809) Property destroyed
- 10.8(809) Disposition of furs

CHAPTER 11
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

- 11.1(17A) Adoption by reference
- 11.2(17A) Report to commission

CHAPTER 12
CONSERVATION EDUCATION

DIVISION I
RESOURCE ENHANCEMENT AND
PROTECTION CONSERVATION EDUCATION PROGRAM (REAP)

- 12.1(455A) Purpose
- 12.2(455A) Conservation education program policy
- 12.3(455A) Conservation education program board
- 12.4(455A) Definitions
- 12.5(455A) Eligibility for funds
- 12.6(455A) Grant applications, general procedures
- 12.7(455A) Conflict of interest
- 12.8(455A) Criteria
- 12.9(455A) Grantee responsibilities
- 12.10(455A) Board review and approval
- 12.11(455A) Waivers of retroactivity
- 12.12(455A) Penalties
- 12.13(455A) Remedy
- 12.14(455A) Termination for convenience
- 12.15(455A) Termination for cause
- 12.16(455A) Responsibility of grantee at termination
- 12.17(455A) Appeals
- 12.18 and 12.19 Reserved

DIVISION II
RECREATION EDUCATION COURSES
PART I
VOLUNTEER INSTRUCTOR CERTIFICATION AND
DECERTIFICATION PROCEDURES

- 12.20(321G,321I,462A,483A) Purpose
- 12.21(321G,321I,462A,483A) Definitions
- 12.22(321G,321I,462A,483A) Certified instructor application process
- 12.23(321G,321I,462A,483A) Requirements for instructor certification
- 12.24(321G,321I,462A,483A) Certified instructor responsibilities and requirements

- 12.25(321G,321I,462A,483A) Grounds for revocation or suspension of instructor certification
- 12.26(321G,321I,462A,483A) Temporary suspensions and immediate revocations of instructor certifications
- 12.27(321G,321I,462A,483A) Termination of certification
- 12.28(321G,321I,462A,483A) Compensation for instructors
- 12.29(321G,321I,462A,483A) Hearing rights
- 12.30 Reserved

PART II
RECREATION EDUCATION PROGRAMS

- 12.31(321I) ATV education program
- 12.32(321G) Snowmobile education program
- 12.33(462A) Boating education program
- 12.34(483A) Hunter safety and ethics education program
- 12.35(321G) Snow groomer operator education program
- 12.36(483A) Bow hunter education program
- 12.37(483A) Fur harvester education program

CHAPTER 13
PERMITS AND EASEMENTS FOR CONSTRUCTION AND RELATED ACTIVITIES
ON PUBLIC LANDS AND WATERS

- 13.1(455A,461A,462A) Purpose
- 13.2(455A,461A,462A) Affected public lands and waters
- 13.3(455A,461A) Definitions

DIVISION I
PERMITS

- 13.4(455A,461A) Permits required
- 13.5(455A,461A) Interest in real estate
- 13.6(455A,461A,462A) Evaluation
- 13.7(455A,461A,462A) Review standards
- 13.8(455A,461A) Leases or easements as a condition of permits
- 13.9(455A,461A,462A) Permit application
- 13.10(455A,461A) Additional information or analysis required for permit review
- 13.11(455A,461A) Permit issued or denied
- 13.12(455A,461A) Authorized agent
- 13.13(455A,461A) Inspection
- 13.14(455A,461A) Additional information or analysis required during term of the permit
- 13.15(455A,461A) Violations; types of enforcement actions; citation and notice of violation
- 13.16(455A,461A) Removal orders
- 13.17(455A,461A) Civil penalties
- 13.18(455A,461A) Report of completion
- 13.19(455A,461A) Final inspection
- 13.20(455A,461A) Permit extensions
- 13.21(455A,461A) Project modifications
- 13.22(455A,461A) Transferability
- 13.23 to 13.50 Reserved

DIVISION II
LEASES AND EASEMENTS

- 13.51(455A,461A) Leases
- 13.52(455A,461A) Easements
- 13.53(455A,461A) Appeals

TITLE II
*LICENSES, PERMITS AND
CONCESSION CONTRACTS*

CHAPTER 14
CONCESSIONS

- 14.1(461A) Definitions
- 14.2(461A) Advertising or notice procedure
- 14.3(461A) Bidding process
- 14.4(461A) Selection of a concessionaire
- 14.5(461A) Concession contract—general
- 14.6(461A) Dispute resolution
- 14.7(461A) Suspension or termination for cause
- 14.8(461A) Severability

CHAPTER 15
GENERAL LICENSE REGULATIONS

- 15.1(483A) Scope

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

- 15.2(483A) Definitions
- 15.3(483A) Form of licenses
- 15.4(483A) Administration fee
- 15.5(483A) Electronic license sales
- 15.6(483A) Paper license sales
- 15.7(483A) Lost or destroyed license blanks
- 15.8(483A) Refund or change requests for special deer and turkey hunting licenses and general licenses
- 15.9(483A) Proof of residency required
- 15.10(483A) Residency status determination
- 15.11(483A) Suspension or revocation of licenses when nonresidents obtain resident licenses
- 15.12 to 15.15 Reserved

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

- 15.16(481A,481B,482,483A,484A,484B) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders
- 15.17(456A) Wildlife violator compact
- 15.18 to 15.20 Reserved

DIVISION III
SPECIAL LICENSES

- 15.21(483A) Fishing license exemption for patients of substance abuse facilities
- 15.22(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals
- 15.23(483A) Free hunting and fishing license for low-income persons 65 years of age and older or low-income persons who are permanently disabled
- 15.24(483A) Free annual fishing license for persons who have severe physical or mental disabilities
- 15.25(483A) Transportation tags for military personnel on leave from active duty
- 15.26 to 15.40 Reserved

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

- 15.41(483A) Hunter safety and ethics education program
 15.42(483A) Testing procedures
 15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors
 15.44 to 15.50 Reserved

DIVISION V
LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

- 15.51(272D) Purpose and use
 15.52(272D) Definitions
 15.53(272D) Requirements of the department
 15.54(272D) No administrative appeal of the department's action
 15.55(272D) District court hearing

CHAPTER 16
DOCKS AND OTHER STRUCTURES ON PUBLIC WATERS

- 16.1(461A,462A) Definitions

DIVISION I
PRIVATE, COMMERCIAL AND PUBLIC DOCKS

- 16.2(461A,462A) Scope of division and classes of permits
 16.3(461A,462A) Standard requirements for all docks
 16.4(461A,462A) Class I permits for standard private docks
 16.5(461A,462A) Class I permits for docks permitted by Corps of Engineers
 16.6(461A,462A) Class II permits for docks authorized by cities and counties that own or otherwise control shoreline property
 16.7(461A,462A) Class III permits for nonstandard private docks
 16.8(461A,462A) Class IV permits for commercial docks
 16.9(461A,462A) Exceptions for renewal of Class III and Class IV permits for existing docks
 16.10(461A,462A) Exceptions to Class III and Class IV permits for new structures
 16.11 Reserved
 16.12(461A,462A) Initial decision and right of appeal
 16.13(461A,462A) Application forms and administrative fees
 16.14 to 16.16 Reserved
 16.17(461A,462A) Duration and transferability of permits; refund of application fees; suspension, modification, or revocation of permits; complaint investigation; property line location
 16.18(461A,462A) Exemptions from winter removal requirement
 16.19(461A,462A) General conditions of all dock permits
 16.20(461A,462A) Permit criteria for rafts, platforms, or other structures
 16.21 to 16.24 Reserved

DIVISION II
DOCK MANAGEMENT AREAS

- 16.25(461A) Designation or modification of dock management areas
 16.26(461A) Procedures and policies for dock site permits and hoist or slip assignments in dock management areas
 16.27(461A) Standard requirements for dock management area docks
 16.28(461A) Dock management area permit restrictions and conditions
 16.29(461A) Fees for docks in dock management areas
 16.30(461A) Suspension, modification or revocation of dock management area permits
 16.31(461A) Persons affected by DMA permit—hearing request

CHAPTER 17
BARGE FLEETING REGULATIONS

17.1(461A)	Purpose
17.2(461A)	Policy
17.3(461A)	Applicability
17.4(461A)	Definitions
17.5(461A)	Barge fleeting leases
17.6(461A)	Restricted areas
17.7(461A)	Prohibited areas
17.8(461A)	Riparian rights
17.9(461A)	Standards
17.10(461A)	Application
17.11(461A)	Application review and approval
17.12(461A)	Lease fee
17.13(461A)	Renewals
17.14(461A)	Disputes concerning leases
17.15(461A)	Lease revocation
17.16(461A)	Nonuse

CHAPTER 18
RENTAL FEE SCHEDULE FOR STATE-OWNED PROPERTY,
RIVERBED, LAKEBED, AND WATERFRONT LANDS

18.1(461A)	General
18.2(461A)	Table 1—Areas designated for industrial or commercial use by the natural resource commission
18.3(461A)	Table 2—Areas designated for noncommercial use or use by nonprofit organizations
18.4(461A)	Other fees

CHAPTER 19
SAND AND GRAVEL PERMITS

19.1(461A)	Purpose
19.2(461A)	Definitions
19.3(461A)	Permit applications
19.4(461A)	Permit conditions and operating procedures

CHAPTER 20
MANUFACTURER'S CERTIFICATE OF ORIGIN

20.1(462A)	Definitions
20.2(462A)	Applicability
20.3(462A)	Certificate of origin—content
20.4(462A)	Procedure—manufacturer
20.5(462A)	Procedure—dealer
20.6(462A)	Procedure—purchaser
20.7(462A)	Procedure—county recorder
20.8(462A)	Vessel titling

TITLE III
ASSISTANCE PROGRAMS

CHAPTER 21
AGRICULTURAL LEASE PROGRAM

21.1(456A)	Purpose
21.2(456A)	Definitions

- 21.3(456A) Agricultural lease policy
- 21.4(456A) Lease procedures

CHAPTER 22

WILDLIFE HABITAT ON PRIVATE LANDS PROMOTION PROGRAM AND HABITAT AND PUBLIC ACCESS PROGRAM

Part 1

WILDLIFE HABITAT ON PRIVATE LANDS PROMOTION PROGRAM

- 22.1(456A,483A) Purpose
- 22.2(456A,483A) Authority
- 22.3(456A,483A) Project scope
- 22.4(456A,483A) Availability of funds
- 22.5(483A) Winter habitat areas
- 22.6(456A,483A) Shelterbelts
- 22.7(456A,483A) Pheasant and quail restoration practices
- 22.8(456A,483A) Cost reimbursement
- 22.9(456A,483A) Wildlife habitat enhancement on public and private lands

Part 2

HABITAT AND PUBLIC ACCESS PROGRAM

- 22.10(456A,483A) Purpose and authority
- 22.11(456A,483A) Definitions
- 22.12(456A,483A) Eligibility
- 22.13(456A,483A) Application procedures
- 22.14(456A,483A) Agreements
- 22.15(456A,483A) Cost reimbursement

CHAPTER 23

WILDLIFE HABITAT PROMOTION WITH LOCAL ENTITIES PROGRAM

- 23.1(483A) Purpose and definitions
- 23.2(483A) Availability of funds
- 23.3(483A) Eligibility
- 23.4(483A) Project limitations
- 23.5(483A) Eligibility for cost-sharing assistance
- 23.6(483A) Application for assistance
- 23.7(483A) Project review and selection
- 23.8(483A) Commission review
- 23.9(483A) Grant amendments
- 23.10(483A) Timely commencement of projects
- 23.11(483A) Project period
- 23.12(483A) Payments
- 23.13(483A) Record keeping and retention
- 23.14(483A) Penalties

CHAPTER 24

BLUFFLANDS PROTECTION PROGRAM AND REVOLVING LOAN FUND

- 24.1(161A) Purpose
- 24.2(161A) Allocation of funds
- 24.3(161A) Definitions
- 24.4(161A) Types of acquisitions
- 24.5(161A) Application for loans
- 24.6(161A) Approval of loan applications
- 24.7(161A) Interest and other terms of loan agreements
- 24.8(161A) Eligible expenditures with loan funds

- 24.9(161A) Custody and management of land during loan term
- 24.10(161A) Loans not to exceed appraised value

CHAPTER 25

CERTIFICATION OF LAND AS NATIVE PRAIRIE OR WILDLIFE HABITAT

- 25.1(427) Purpose
- 25.2(427) Definitions
- 25.3(427) Restrictions
- 25.4(427) Maintenance
- 25.5(427) Certification
- 25.6(427) Application for exemption
- 25.7(427) Decertification

CHAPTER 26

RELOCATION ASSISTANCE

- 26.1(316) Definitions
- 26.2(316) Actual reasonable moving costs and related expenses
- 26.3(316) Replacement housing payments for homeowners
- 26.4(316) Replacement housing payments for tenants and certain others
- 26.5(316) Notice of relocation assistance advisory service
- 26.6(316) Preconstruction project certificate
- 26.7(316) Record of payment determinations and claims for benefits paid
- 26.8(316) Last resort housing

CHAPTER 27

LANDS AND WATERS CONSERVATION FUND PROGRAM

- 27.1(456A) Purpose
- 27.2(456A) Apportionment distribution
- 27.3(456A) Eligibility requirements
- 27.4(456A) Assistance ceiling
- 27.5(456A) Grant application submission
- 27.6(456A) Project review and selection
- 27.7(456A) Public participation
- 27.8(456A) Commission review
- 27.9(456A) Federal review
- 27.10(456A) Grant amendments
- 27.11(456A) Timely commencement of projects
- 27.12(456A) Project period
- 27.13(456A) Reimbursements
- 27.14(456A) Ineligible items
- 27.15(456A) Record keeping and retention

CHAPTER 28

SNOWMOBILE AND ALL-TERRAIN VEHICLE REGISTRATION
REVENUE COST-SHARE PROGRAM

- 28.1(321G) Definitions
- 28.2(321G) Purpose and intent
- 28.3(321G) Distribution of funds
- 28.4(321G) Application procedures
- 28.5(321G) Review and selection committees
- 28.6(321G) Director's review of approved projects
- 28.7(321G) Project selection criteria
- 28.8(321G) Eligibility of projects

28.9(321G)	Use of funded items
28.10(321G)	Disposal of equipment, facilities or property
28.11(321G)	Record keeping
28.12(321G)	Sponsors bonded
28.13(321G)	Items eligible for funding specific to the all-terrain vehicle program
28.14(321G)	Items eligible for funding specific to the snowmobile program
28.15(321G)	Competitive bids
28.16(321G)	Prepayment for certain anticipated costs
28.17(321G)	Expense documentation, balance payment or reimbursement
28.18(321G)	Use of funds

CHAPTER 29

LOCAL RECREATION INFRASTRUCTURE GRANTS PROGRAM

29.1(8,77GA,ch1219)	Purpose
29.2(8,77GA,ch1219)	Definitions
29.3(8,77GA,ch1219)	Eligibility requirements
29.4(8,77GA,ch1219)	Assistance ceiling and cost share
29.5(8,77GA,ch1219)	Minimum grant amount
29.6(8,77GA,ch1219)	Grant application submission
29.7(8,77GA,ch1219)	Project review and selection
29.8(8,77GA,ch1219)	Rating system not used
29.9(8,77GA,ch1219)	Applications not approved for funding
29.10(8,77GA,ch1219)	Commission review
29.11(8,77GA,ch1219)	Grant amendments
29.12(8,77GA,ch1219)	Timely commencement of projects
29.13(8,77GA,ch1219)	Payments
29.14(8,77GA,ch1219)	Record keeping and retention
29.15(8,77GA,ch1219)	Eligible projects
29.16(8,77GA,ch1219)	Project life and recovery of funds
29.17(8,77GA,ch1219)	Unlawful use of funds
29.18(8,77GA,ch1219)	Remedy
29.19(8,77GA,ch1219)	Ineligibility

CHAPTER 30

WATERS COST-SHARE AND GRANT PROGRAMS

DIVISION I

WATER RECREATION ACCESS COST-SHARE PROGRAM

30.1(452A)	Title and purpose
30.2(452A)	Availability of funds
30.3(452A)	Eligibility of development projects
30.4(452A)	Eligibility of acquisition projects
30.5(452A)	Projects not eligible
30.6(452A)	Waiver of retroactivity
30.7(452A)	Establishing project priorities
30.8(452A)	Application procedures
30.9(452A)	Cost-sharing rates
30.10(452A)	Joint sponsorship
30.11(452A)	Control of project site
30.12(452A)	Project agreements
30.13(452A)	Reimbursement procedures
30.14(77GA,SF2381)	Implementation of pilot program for state and local cooperative lake rehabilitation

30.15 to 30.50 Reserved

DIVISION II

WATER TRAILS DEVELOPMENT PROGRAM AND LOW-HEAD DAM PUBLIC HAZARD PROGRAM

- 30.51(455A,461A,462A) Definitions
- 30.52(455A,461A,462A) Purpose and intent
- 30.53(455A,461A,462A) Program descriptions
- 30.54(455A,461A,462A) Announcement of funding opportunity
- 30.55(455A,461A,462A) Grant requirements
- 30.56(455A,461A,462A) Application procedures
- 30.57(455A,461A,462A) Proposal evaluation
- 30.58(455A,461A,462A) Sponsor eligibility
- 30.59(455A,461A,462A) Project eligibility
- 30.60(455A,461A,462A) Cost-share requirements
- 30.61(455A,461A,462A) Evaluation criteria
- 30.62(455A,461A,462A) Disbursement of awards
- 30.63(455A,461A,462A) Water trails advisory committee

CHAPTER 31

PUBLICLY OWNED LAKES PROGRAM

- 31.1(456A) Purpose
- 31.2(456A) Definitions
- 31.3(456A) Priority of watersheds
- 31.4(456A) Application
- 31.5(456A) Application review
- 31.6(456A) Commission approvals

CHAPTER 32

PRIVATE OPEN SPACE LANDS

- 32.1(9H) Applicability
- 32.2(9H) Definition

CHAPTER 33

RESOURCE ENHANCEMENT AND PROTECTION PROGRAM:
COUNTY, CITY AND PRIVATE OPEN SPACES GRANT PROGRAMS

Part 1
GENERAL PROVISIONS

- 33.1(455A) Purpose
- 33.2(455A) Resource enhancement policy
- 33.3(455A) Definitions
- 33.4(455A) Restrictions
- 33.5(455A) Grant applications, general procedures
- 33.6(455A) Appraisals
- 33.7(455A) Groundwater hazard statements
- 33.8(455A) Rating systems not used
- 33.9(455A) Applications not selected for grants
- 33.10(455A) Similar development projects
- 33.11(455A) Commission review and approval
- 33.12(455A) Timely commencement and completion of projects
- 33.13(455A) Waivers of retroactivity
- 33.14(455A) Project amendments
- 33.15(455A) Payments
- 33.16(455A) Record keeping and retention
- 33.17(455A) Penalties

33.18	Reserved
33.19(455A)	Property tax reimbursement
33.20(455A)	Public hearing
33.21(455A)	Conflict of interest
33.22(455A)	Public communications
33.23 to 33.29	Reserved

Part 2
COUNTY GRANTS

33.30(455A)	County conservation account
33.31 to 33.39	Reserved

Part 3
CITY GRANTS

33.40(455A)	Competitive grants to cities
33.41 to 33.49	Reserved

Part 4
PRIVATE GRANTS

33.50(455A)	Private cost-sharing program
-------------	------------------------------

CHAPTER 34
COMMUNITY FORESTRY
GRANT PROGRAM (CFGP)

34.1(461A)	Purpose
34.2(461A)	Definitions
34.3(461A)	Availability of funds
34.4(461A)	Eligibility of forestry development projects
34.5(461A)	Eligibility of community tree planting projects
34.6(461A)	Projects not eligible
34.7(461A)	Eligible applicants
34.8(461A)	Establishing project priorities
34.9(461A)	Application procedures
34.10(461A)	Requirements for funding
34.11(461A)	Project agreements
34.12(461A)	Reimbursement procedures

CHAPTER 35

FISH HABITAT PROMOTION FOR COUNTY CONSERVATION BOARDS

35.1(483A)	Purpose and definitions
35.2(483A)	Availability of funds
35.3(483A)	Program eligibility
35.4(483A)	Eligibility for cost-sharing assistance
35.5(483A)	Application for assistance
35.6(483A)	Project review and selection
35.7(483A)	Commission review
35.8(483A)	Grant amendments
35.9(483A)	Timely commencement of projects
35.10(483A)	Project period
35.11(483A)	Payments
35.12(483A)	Record keeping and retention
35.13(483A)	Penalties

TITLE IV
*RECREATIONAL VESSEL AND VEHICLE
 REGISTRATION AND SAFETY*

CHAPTER 36
 GREEN VALLEY LAKE SPECIAL WATER ACTIVITY RULES

36.1(462A)	General
36.2(462A)	Inboard boats
36.3(462A)	Racing craft
36.4(462A)	Wake
36.5(462A)	Speed
36.6(462A)	Hours
36.7(462A)	Ski zone
36.8(462A)	Traffic pattern
36.9(462A)	Designated activities in ski zone
36.10(462A)	Designated areas
36.11(462A)	Traffic
36.12(462A)	Lifesaving device
36.13(462A)	Speed
36.14(462A)	Distance from shore
36.15(462A)	Horsepower limitation

CHAPTER 37
 BOATING SAFETY EQUIPMENT

37.1(462A)	Fire extinguishers
37.2(462A)	Flame arrester required
37.3 to 37.5	Reserved
37.6(462A)	Lights on vessels
37.7(462A)	Lighting requirements for sailing vessels
37.8(462A)	Sailing vessels with auxiliary power
37.9 to 37.12	Reserved
37.13(462A)	Buoyant safety equipment

CHAPTER 38
 BOAT REGISTRATION AND NUMBERING

38.1(462A)	Emblem placed
38.2 to 38.5	Reserved
38.6(462A)	Procedure for application for boat registration number—content
38.7 to 38.9	Reserved
38.10(462A)	Information on certificate
38.11(462A)	Registration applied for card
38.12(462A)	Vessels in storage
38.13 and 38.14	Reserved
38.15(462A)	Numbering pattern to be used
38.16 to 38.18	Reserved
38.19(462A)	Display of number on vessel, as to size, block type and contrasting color
38.20(462A)	Special certificates for boat dealers or manufacturers
38.21(462A)	Boat dealer's annual report of vessels with expired registrations
38.22 to 38.24	Reserved
38.25(462A)	Number designating passenger capacity
38.26(462A)	Monthly reports by county recorders
38.27 to 38.29	Reserved
38.30(462A)	Boats for hire

CHAPTER 39
BOATING PASSENGER CAPACITY

- 39.1(462A) U.S. Coast Guard capacity rating
 39.2(462A) Vessels assigned a capacity rating by the manufacturer
 39.3(462A) Vessels not containing capacity rating information
 39.4(462A) Incorrect registration

CHAPTER 40
BOATING SPEED AND DISTANCE ZONING

- 40.1(462A) Restricted areas
 40.2(462A) Uniform buoy system
 40.3(462A) Commission approval
 40.4(462A) Right for aggrieved party to appeal
 40.5(462A) Rathbun Lake, Appanoose County—zoned areas
 40.6(462A) Red Rock Lake, Marion County—zoned areas
 40.7(462A) Coralville Lake, Johnson County—zoned areas
 40.8(462A) Saylorville Lake, Polk County—zoned areas
 40.9(462A) Lake Odessa in Louisa County
 40.10(462A) Mississippi River lock and dam safety zone
 40.11(462A) Joyce Slough Area
 40.12(462A) Swan Slough, Camanche, Iowa
 40.13(462A) Massey Slough
 40.14(462A) Black Hawk County waters
 40.15(462A) Mitchell County waters
 40.16(462A) Maquoketa River
 40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County
 40.18(462A) Speed restrictions on Lake Manawa
 40.19(462A) Zoning of Little Wall Lake
 40.20(462A) Lake Icaria, Adams County—watercraft use
 40.21(462A) Zoning of the Des Moines River
 40.22(462A) Upper Gar Lake, Dickinson County
 40.23(462A) Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County
 40.24(462A) Mt. Ayr City Lake (Loch Ayr)
 40.25(462A) Iowa River in Iowa City, Johnson County
 40.26(462A) Zoning of the Mississippi River, Dubuque, Dubuque County
 40.27(462A) Zoning Harpers Slough, Harpers Ferry, Allamakee County
 40.28(462A) Black Hawk Lake, Sac County—zoned areas
 40.29(462A) Speed and other restrictions on Brown's Lake, Woodbury County
 40.30(462A) Speed and other restrictions on Snyder Bend Lake, Woodbury County
 40.31(462A) Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County
 40.32(462A) Spirit Lake, Dickinson County—zoned areas
 40.33(462A) Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park
 40.34(462A) Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula
 40.35(462A) Speed restrictions on the Greene Impoundment of the Shell Rock River
 40.36(462A) Zoning of the Iowa River, Iowa Falls, Hardin County
 40.37(462A) Zoning of Crystal Lake
 40.38(462A) Five Island Lake, Palo Alto County
 40.39(462A) Lost Island Lake, Palo Alto and Clay Counties
 40.40(462A) Ingham Lake, Emmet County
 40.41(462A) Storm Lake, Buena Vista County

40.42(462A)	Raccoon River Regional Park Lake, Polk County
40.43(462A)	Zoning of the Mississippi River, Bellevue, Jackson County
40.44(462A)	Three Mile Lake, Union County—watercraft use
40.45(462A)	Zoning of the Cedar River
40.46(462A)	Zoning of Carter Lake, Pottawattamie County
40.47(462A)	Zoning of the Mississippi River, McGregor, Clayton County
40.48(462A)	Zoning of the Mississippi River, Marquette, Clayton County
40.49(462A)	Zoning of Green Island, Jackson County
40.50(462A)	Mooring of vessels on riparian property of the state of Iowa
40.51(462A)	Little River Lake, Decatur County
40.52(462A)	Zoning of the Mississippi River, Johnson Slough, Clayton County
40.53(462A)	Zoning of the Mississippi River, Mud Lake, Dubuque County
40.54(462A)	Nighttime speed limit, Dickinson County
40.55(462A)	Zoning of Clear Lake, Cerro Gordo County
40.56(462A)	Zoning of Mississippi River, Des Moines County, city of Burlington
40.57(462A)	Zoning of Catfish Creek, Mines of Spain State Recreation Area, Dubuque County
40.58(462A)	Zoning of Lake Cornelia, Wright County
40.59(462A)	Zoning of lakes in Dickinson County

CHAPTER 41

BOATING NAVIGATION AIDS

41.1(462A)	Definitions
41.2(462A)	Waterway markers
41.3(462A)	Authority to place markers
41.4(462A)	Maintenance of waterway markers
41.5 and 41.6	Reserved
41.7(462A)	Display of waterway markers
41.8(462A)	Specifications for waterway markers
41.9(462A)	Waterway marking devices
41.10(462A)	The diver's flag

CHAPTER 42

BOATING ACCIDENT REPORTS

42.1(462A)	Accident report
42.2(462A)	Procedure
42.3(462A)	Contents

CHAPTER 43

MOTORBOAT NOISE

43.1(462A)	Definitions
43.2(462A)	Sound level limitation
43.3(462A)	Serviceability

CHAPTER 44

SPECIAL EVENTS AND FIREWORKS DISPLAYS

44.1(321G,321I,461A,462A,481A)	Scope
44.2(321G,321I,461A,462A,481A)	Definitions

DIVISION I
SPECIAL EVENTS

44.3(321G,321I,461,462A,481A)	Permit required
44.4(321G,321I,461A,462A,481A)	Permit conditions
44.5(321G,321I,461A,462A,481A)	Application procedures

- 44.6(321G,321I,462A) Alternate dates for snowmobile, boating, all-terrain vehicle, off-highway vehicle, and off-road motorcycle special events
- 44.7(321G,321I,461A,462A,481A) Insurance coverage
- 44.8(321G,321I,461A,462A,481A) Fees and exceptions
- 44.9(321G,461A) Structures placed on ice during a special event
- 44.10(462A) Boating special events—registration exemptions
- 44.11(462A) Mississippi River or Missouri River
- 44.12(321G,321I,461A,462A,481A) Other requirements and permits
- 44.13(321G,321I,461A,462A,481A) Authority to cancel or stop a special event
- 44.14(321G,321I,461A,462A,481A) Nonexclusive use of area

DIVISION II
FIREWORKS DISPLAYS

- 44.15(461A) Entities eligible for permits
- 44.16(461A) Permit conditions
- 44.17(461A) Application procedures
- 44.18(461A) Fireworks display procedures
- 44.19(461A) Fees
- 44.20(461A) Insurance
- 44.21(461A) Concessions

CHAPTER 45
BOAT MOTOR REGULATIONS

- 45.1(462A) Horsepower rating
- 45.2(462A) Alteration of horsepower rating
- 45.3(462A) Propulsion mechanism not in use
- 45.4(462A) Horsepower limitations on artificial lakes
- 45.5(462A) Artificial marshes

CHAPTER 46
ALL-TERRAIN VEHICLES, OFF-ROAD MOTORCYCLES AND
OFF-ROAD UTILITY VEHICLES

DIVISION I
REGISTRATION, RENEWAL, TITLING, DECAL PLACEMENT
AND ACCIDENT REPORTS

- 46.1(321I) Definitions
- 46.2(321I) Off-road motorcycles
- 46.3(321I) Off-road utility vehicles
- 46.4(321I) Operation on roadways, highways, streets, and snowmobile trails
- 46.5(321I) Registration for all-terrain vehicles and off-road motorcycles
- 46.6(321I) Nonresident user permits
- 46.7(321I) Display of registration and user permit decals
- 46.8(321I) Registration certificate
- 46.9(321I) Owner's certificate of title
- 46.10(321I) Procedures for application and for issuance of a vehicle identification number (VIN) for homebuilt regulated vehicles
- 46.11(321I) Accident report
- 46.12(321I) Sound level limitation
- 46.13 to 46.20 Reserved

DIVISION II
ALL-TERRAIN VEHICLE DEALERS

- 46.21(321I) Purpose
- 46.22(321I) Definitions

46.23(321I)	Dealer's established place of business
46.24(321I)	Zoning
46.25(321I)	Sales tax permit
46.26(321I)	Special registration certificates for manufacturers, distributors, and dealers
46.27(321I)	Information provided to purchaser
46.28(321I)	Right of inspection
46.29(321I)	Denial or revocation
46.30 to 46.50	Reserved

DIVISION III
REGULATION OF DESIGNATED RIDING AREAS

46.51(321I)	Definitions
46.52(321I)	Designated riding areas
46.53(321I)	Department law enforcement at designated riding areas
46.54(321I)	General rules for regulated vehicle operation in designated riding areas
46.55(321I)	Unauthorized vehicles
46.56(321I)	Parking and unloading areas
46.57(321I)	Operation with passengers
46.58(321I)	Off-road utility vehicle requirements
46.59(321I)	Youth operational areas
46.60(321I)	Unlawful operation
46.61(321I)	Alcohol prohibited
46.62(321I)	Pets
46.63(321I)	Camping

CHAPTER 47
SNOWMOBILES

DIVISION I
REGISTRATION, RENEWAL, TITLING, DECAL PLACEMENT
AND ACCIDENT REPORTS

47.1(321G)	Definitions
47.2(321G)	Operation on roadways, highways, streets and snowmobile trails
47.3(321G)	Registration for snowmobiles
47.4(321G)	Nonresident user permits
47.5(321G)	Display of registration and user permit decals
47.6(321G)	Registration certificate
47.7(321G)	Owner's certificate of title
47.8(321G)	Procedures for application and for issuance of a vehicle identification number (VIN) for homebuilt snowmobiles
47.9(321G)	Accident report
47.10 to 47.20	Reserved

DIVISION II
SNOWMOBILE DEALERS

47.21(321G)	Purpose
47.22(321G)	Definitions
47.23(321G)	Dealer's established place of business
47.24(321G)	Zoning
47.25(321G)	Sales tax permit
47.26(321G)	Special registration certificates for manufacturers, distributors and dealers
47.27(321G)	Information provided to purchasers
47.28(321G)	Right of inspection
47.29(321G)	Denial or revocation

CHAPTER 48

INSPECTION OF PERMANENTLY MOORED VESSELS

- 48.1(462A) Purpose
- 48.2(462A) Definitions
- 48.3(462A) Inspection requirements
- 48.4(462A) Inspectors
- 48.5(462A) Statewide inspection contract
- 48.6(462A) Submission
- 48.7(462A) Notification to the commission

CHAPTER 49

OPERATION OF MOTOR VEHICLES IN MEANDERED
STREAMS, NAVIGABLE STREAMS AND TROUT STREAMS

- 49.1(462A) Purpose and intent
- 49.2(462A) Definitions
- 49.3(462A) Stream identification process
- 49.4(462A) Motor vehicle prohibition in meandered streams, trout streams and navigable streams
- 49.5(462A) Motor vehicle prohibition in meandered streams

CHAPTER 50

ALL-TERRAIN VEHICLE, OFF-ROAD MOTORCYCLE, OFF-ROAD UTILITY VEHICLE,
SNOWMOBILE AND VESSEL BONDING

- 50.1(321G,321I) Definitions

DIVISION I

ALL-TERRAIN VEHICLES, OFF-ROAD MOTORCYCLES,
OFF-ROAD UTILITY VEHICLES AND SNOWMOBILES

- 50.2(321G,321I) Bond required before issuance of title or registration
- 50.3 to 50.9 Reserved

DIVISION II
VESSELS

- 50.10(462A) Bond required before issuance of title or registration

TITLE V

MANAGEMENT AREAS AND PRACTICES

CHAPTER 51

GAME MANAGEMENT AREAS

- 51.1(481A) Definitions
- 51.2(481A) Jurisdiction
- 51.3(481A) Use of firearms
- 51.4(481A) Use of horses on game management areas
- 51.5(481A) Dogs prohibited—exception
- 51.6(481A) Use of blinds and decoys on game management areas
- 51.7(481A) Trapping on game management areas
- 51.8(481A) Motor vehicle restrictions
- 51.9(481A) Employees exempt
- 51.10(481A) Use of nontoxic shot on wildlife areas
- 51.11(481A) Rock climbing and rappelling
- 51.12(481A) Camping restrictions

CHAPTER 52
WILDLIFE REFUGES

52.1(481A) Established

CHAPTER 53
CONTROLLED HUNTING AREAS

53.1(481A) Definitions

CHAPTER 54
RESTRICTIONS ON INTRODUCTION AND REMOVAL OF PLANT LIFE

54.1(461A) Mushrooms and asparagus

54.2(461A) Fruit

54.3(461A) American ginseng

54.4(461A) Trees

54.5(461A) Aquatic plants

CHAPTER 55
NONPERMANENT STRUCTURES

55.1(461A) Ice fishing shelters

CHAPTERS 56 to 60
Reserved

TITLE VI
PARKS AND RECREATION AREAS

CHAPTER 61
STATE PARKS AND RECREATION AREAS

61.1(461A) Applicability

61.2(461A) Definitions

61.3(461A) Establishment of centralized reservation system operating procedures and policies

61.4(461A) Camping

61.5(461A) Rental facilities

61.6(461A) Vessel storage fees

61.7(461A) Restrictions—area and use

61.8(461A) Certain conditions of public use applicable to specific parks and recreation areas

61.9(461A) Mines of Spain hunting, trapping and firearms use

61.10(461A) After-hours fishing—exception to closing time

61.11(461A) Designated areas for after-hours fishing

61.12(461A) Vessels prohibited

61.13(461A) Severability

61.14(461A) Restore the outdoors program

61.15(461A,463C) Honey Creek Resort State Park

CHAPTER 62
STATE FOREST CAMPING

62.1(461A) Applicability

62.2(461A) Definitions

62.3(461A) Camping areas established and marked

62.4(461A) Campground reservations

62.5(461A) Camping fees and registration

62.6(461A) Camping restrictions

62.7(461A) Camping time limit

62.8(461A) Camping refused

62.9(461A) Firearms use prohibited

62.10(461A)	Hours
62.11(461A)	Horses and pets
62.12(461A)	Noise

CHAPTER 63
KEG BEER RULES

63.1(111,123)	Purpose
63.2(111,123)	Applicability
63.3(111,123)	Definitions
63.4(111,123)	Prohibited areas
63.5(111,123)	Procedure
63.6(461A,123)	Deposit disposition
63.7(111,123)	Responsibility agreement

CHAPTER 64
METAL DETECTORS USE IN STATE AREAS

64.1(461A)	Definitions
64.2(461A)	Use areas
64.3(461A)	Archaeological/scientific studies
64.4(461A)	Found items
64.5(461A)	Lost item search by owner
64.6(461A)	Tools used
64.7(461A)	Digging limitations and restoration
64.8(461A)	Disposal of litter

CHAPTER 65
Reserved

CHAPTER 66
SAYLORVILLE MULTIUSE TRAIL

66.1(461A,481A)	Applicability
66.2(456A,481A)	Wildlife refuge
66.3(481A)	Hunting and trapping restrictions
66.4(461A)	Area use restrictions

CHAPTER 67
DEVELOPMENT AND MANAGEMENT OF RECREATION TRAILS
ON STATE FORESTS, PARKS, PRESERVES AND RECREATION AREAS

67.1(456A,461A)	Applicability
67.2(456A,461A)	Definitions
67.3(456A,461A)	Purpose
67.4(456A,461A)	Establishment of trails
67.5(456A,461A)	Designation of recreation trails
67.6(456A,461A)	Guidelines for trail location
67.7(456A,461A)	Control of trail use
67.8(456A,461A)	Use of designated trails

CHAPTERS 68 to 70
Reserved

TITLE VII
FORESTRYCHAPTER 71
NURSERY STOCK SALE TO THE PUBLIC

- 71.1(456A,461A) Purpose
- 71.2(456A,461A) Procedures
- 71.3(456A,461A) Nursery stock prices

CHAPTER 72
TIMBER BUYERS

- 72.1(456A) Definitions
- 72.2(456A) Applicability of rules
- 72.3(456A) Forms

CHAPTER 73
FOREST AND FRUIT-TREE RESERVATIONS

- 73.1(427C,456A) Criteria for establishing and maintaining forest and fruit-tree reservations
- 73.2(427C,456A) County assessor's annual report on forest and fruit-tree reservations to the department of natural resources

CHAPTER 74
FOREST LAND ENHANCEMENT PROGRAM (FLEP)

- 74.1(461A) Purpose
- 74.2(461A) Definitions
- 74.3(461A) Project scope
- 74.4(461A) Availability of funds
- 74.5(461A) Forest land enhancement program areas
- 74.6(461A) Cost reimbursement

CHAPTER 75
ReservedTITLE VIII
SEASONS, LIMITS, METHODS OF TAKECHAPTER 76
UNPROTECTED NONGAME

- 76.1(481A) Species

CHAPTER 77
ENDANGERED AND THREATENED PLANT AND ANIMAL SPECIES

- 77.1(481B) Definitions
- 77.2(481B) Endangered, threatened, and special concern animals
- 77.3(481B) Endangered, threatened, and special concern plants
- 77.4(481B) Exemptions

CHAPTER 78
GINSENG HARVESTING AND SALE

- 78.1(456A) Purpose
- 78.2(456A) Scope
- 78.3(456A) Definitions
- 78.4(456A) Season for legal harvest
- 78.5(456A) General prohibitions
- 78.6(456A) Ginseng permits

78.7(456A)	Dealers—record keeping
78.8(456A)	Dealer locations
78.9(456A)	Certificates of origin
78.10(456A)	Inspection
78.11(456A)	Restrictions and prohibitions for harvesting wild ginseng
78.12(456A)	Additional restrictions and prohibitions for wild ginseng
78.13(456A)	Compliance with laws
78.14(456A)	Violations of this chapter
78.15(456A)	Possession
78.16(456A)	Valuation
78.17(456A)	Revocation of permits
78.18(456A)	Reciprocity

CHAPTER 79

FISH STOCKING PROCEDURES AND FEES FOR PRIVATE WATERS

79.1(481A)	Purpose
79.2(481A)	Application procedures
79.3(481A)	Fish stocks
79.4(481A)	Fees

CHAPTER 80

SALVAGE OF FISH AND GAME

80.1(481A)	Salvage
80.2(481A)	Game killed by motor vehicle
80.3(481A)	Confiscated fish or game

CHAPTER 81

FISHING REGULATIONS

81.1(481A)	Seasons, territories, daily bag limits, possession limits, and length limits
81.2(481A)	Exceptions to seasons and limits, set in 81.1(481A)

CHAPTER 82

COMMERCIAL FISHING

INLAND WATERS

82.1(482)	Contract policy
-----------	-----------------

MISSISSIPPI AND MISSOURI RIVERS

82.2(482)	Commercial taking
-----------	-------------------

CHAPTER 83

SCUBA AND SKIN SPEARING OF ROUGH FISH

83.1(481A)	When permitted
83.2(481A)	Prohibited areas
83.3(481A)	Permitted equipment
83.4(481A)	Prohibited equipment
83.5(481A)	Diver's flag
83.6(481A)	Employees exempt

CHAPTER 84
PROMISCUOUS FISHING

84.1(481A) General

CHAPTER 85
TROTLINES

85.1(481A) Trotlines

CHAPTER 86
TURTLES

86.1(481A,482) Taking

CHAPTER 87
MUSSEL REGULATIONS

87.1(481A) Seasons, areas, methods, species, limits

CHAPTER 88
FISHING TOURNAMENTS

88.1(462A,481A) Definition
88.2(462A,481A) Permit required
88.3(462A,481A) Application procedures
88.4(462A,481A) Permit conditions

CHAPTER 89
AQUACULTURE

89.1(481A) Approved aquaculture species
89.2(481A) Importation permit
89.3(481A) Disease-free certification

CHAPTER 90
AQUATIC INVASIVE SPECIES

90.1(456A) Definitions
90.2(456A) Aquatic invasive species
90.3(456A) Restrictions
90.4(456A) Infested waters

CHAPTER 91
WATERFOWL AND COOT HUNTING SEASONS

91.1(481A) Duck hunting
91.2(481A) Coots (split season)
91.3(481A) Goose hunting
91.4(481A) Closed areas
91.5(481A) Canada goose hunting within closed areas
91.6(481A) Youth waterfowl hunt

CHAPTER 92
MIGRATORY GAME BIRDS

92.1(481A) General
92.2(481A) Duck stamp
92.3(481A) Hunting methods
92.4(481A) Restrictions applicable to possession, tagging, and record-keeping requirements
92.5(481A) Transportation within the state or between states
92.6(481A) Wounded, live migratory game birds
92.7(481A) Harvest information program (HIP)

CHAPTER 93

COMMERCIAL USE OF CAPTIVE-REARED WATERFOWL

- 93.1(481A) General
- 93.2(481A) Required markings
- 93.3(481A) Definitions
- 93.4(484B) Marked for shooting
- 93.5(481A) Commercial sale of captive-reared waterfowl by a taxidermist

CHAPTER 94

NONRESIDENT DEER HUNTING

- 94.1(483A) Licenses
- 94.2(483A) Season dates
- 94.3(483A) Shooting hours
- 94.4(481A) Limits
- 94.5(483A) Zones open to hunting
- 94.6(483A) License quotas
- 94.7(483A) Method of take
- 94.8(483A) Application procedure
- 94.9(483A) Transportation tag
- 94.10(481A) Deer hunting season for severely disabled persons
- 94.11(481A) Harvest reporting
- 94.12(481A) January antlerless season

CHAPTER 95

GAME HARVEST REPORTING AND LANDOWNER-TENANT REGISTRATION

- 95.1(481A) Harvest reporting system
- 95.2(481A) Verifying eligibility for free landowner or tenant licenses

CHAPTER 96

PHEASANT, QUAIL AND GRAY (HUNGARIAN)
PARTRIDGE HUNTING SEASONS

- 96.1(481A) Pheasant season
- 96.2(481A) Gray (Hungarian) partridge season
- 96.3(481A) Quail season

CHAPTER 97

COMMON SNIPE, VIRGINIA RAIL AND SORA, WOODCOCK
AND RUFFED GROUSE HUNTING SEASONS

- 97.1(481A) Common snipe season
- 97.2(481A) Virginia rail and sora season
- 97.3(481A) Woodcock season
- 97.4(481A) Ruffed grouse season

CHAPTER 98

WILD TURKEY SPRING HUNTING

RESIDENT WILD TURKEY SPRING HUNTING

- 98.1(483A) General
- 98.2(483A) Means and method of take
- 98.3(483A) Procedures to obtain licenses
- 98.4(483A) Transportation tag
- 98.5(483A) Eligibility for free landowner/tenant turkey licenses
- 98.6(483A) Youth spring wild turkey hunt
- 98.7(481A) Harvest reporting

98.8 Reserved

NONRESIDENT WILD TURKEY SPRING HUNTING

98.9(483A) General
 98.10(483A) Zones open to hunting
 98.11(483A) License quotas
 98.12(483A) Means and method of take
 98.13(483A) Application procedure
 98.14(483A) Transportation tag
 98.15(481A) Harvest reporting

CHAPTER 99
 WILD TURKEY FALL HUNTING

99.1(481A) General
 99.2(481A) Licenses
 99.3(481A) Seasons
 99.4(481A) Zones
 99.5(481A) Quotas
 99.6(481A) Daily, season, and possession bag limits
 99.7(481A) Shooting hours
 99.8(481A) Means and method of take
 99.9(481A) Procedures to obtain licenses
 99.10(481A) Transportation tag
 99.11(481A) Eligibility for free landowner/tenant turkey licenses
 99.12(481A) Harvest reporting

CHAPTER 100
 CROW AND PIGEON REGULATIONS

100.1(481A) Crow season
 100.2(481A) Pigeons

CHAPTER 101
 FALCONRY REGULATIONS

101.1(481A) Falconry regulations
 101.2(481A) Facilities and equipment
 101.3(481A) Taking and possession provision
 101.4(481A) Annual reports
 101.5(481A) Other provisions
 101.6(481A) Compliance

CHAPTER 102
 FALCONRY REGULATIONS FOR HUNTING GAME

102.1(481A) General
 102.2(481A) Migratory bird regulations
 102.3(481A) Small game
 102.4(481A) Means and methods of take
 102.5(481A) Exclusions

CHAPTER 103
 MOBILE RADIO TRANSMITTERS

103.1(481A) Definitions
 103.2(481A) Falconry
 103.3(481A) Hunting dogs

CHAPTER 104

WILDLIFE IMPORTATION, TRANSPORTATION AND DISEASE MONITORING

- 104.1(481A) Definitions
- 104.2(481A) Chronic wasting disease in captive cervids
- 104.3(481A) Chronic wasting disease in captive cervids—herd monitoring program
- 104.4(481A) Identification of animals
- 104.5(481A) Supervision of the CCWDSI program
- 104.6(481A) Surveillance procedures
- 104.7(481A) Official cervid CWD tests
- 104.8(481A) Investigation of CWD affected animals identified through surveillance
- 104.9(481A) Duration of quarantine
- 104.10(481A) Herd plan
- 104.11(481A) Identification and disposal requirements
- 104.12(481A) Cleaning and disinfecting
- 104.13(481A) Methods for obtaining certified CWD cervid herd status
- 104.14(481A) Recertification of CWD cervid herds
- 104.15(481A) Movement into a certified CWD cervid herd
- 104.16(481A) Movement into a monitored CWD cervid herd
- 104.17(481A) Recognition of monitored CWD cervid herds
- 104.18(481A) Recognition of certified CWD cervid herds
- 104.19(481A) Intrastate movement requirements
- 104.20(481A) Import requirements
- 104.21(481A) Prohibited movement of cervid carcasses
- 104.22(481A) Inspection

CHAPTER 105

DEER POPULATION MANAGEMENT ZONES

- 105.1(481A) Purpose
- 105.2(481A) Definitions
- 105.3(481A) Special deer management zones
- 105.4(481A) State parks and recreation areas
- 105.5(481A) Urban deer management zones
- 105.6(481A) Iowa Army Ammunition Plant (IAAP) deer management zone
- 105.7(481A) County park deer management zones
- 105.8(481A) Special deer management zones on private land

CHAPTER 106

DEER HUNTING BY RESIDENTS

- 106.1(481A) Licenses
- 106.2(481A) Season dates
- 106.3(481A) Shooting hours
- 106.4(481A) Limits
- 106.5(481A) Areas closed to hunting
- 106.6(481A) Paid deer license quotas and restrictions
- 106.7(481A) Method of take
- 106.8(481A) Procedures to obtain licenses
- 106.9(481A) Transportation tag
- 106.10(481A) Youth deer and severely disabled hunts
- 106.11(481A) Deer depredation management
- 106.12(481A) Eligibility for free landowner/tenant deer licenses
- 106.13(481A) Harvest reporting

CHAPTER 107
RABBIT AND SQUIRREL HUNTING

- 107.1(481A) Cottontail rabbit season
- 107.2(481A) Jackrabbit season
- 107.3(481A) Squirrel season

CHAPTER 108
MINK, MUSKRAT, RACCOON, BADGER, OPOSSUM, WEASEL,
STRIPED SKUNK, FOX (RED AND GRAY), BEAVER, COYOTE, RIVER OTTER,
BOBCAT, GRAY (TIMBER) WOLF AND SPOTTED SKUNK SEASONS

- 108.1(481A) Mink, muskrat and weasel
- 108.2(481A) Raccoon, badger, opossum and striped skunk
- 108.3(481A) Red and gray fox
- 108.4(481A) Beaver
- 108.5(481A) Coyote
- 108.6(481A) Gray (timber) wolf and spotted skunk
- 108.7(481A) River otter and bobcat
- 108.8(481A) Accidental capture of a river otter or bobcat during a closed season
- 108.9(481A) Trapping restrictions

CHAPTER 109
GROUNDHOG SEASON

- 109.1(481A) Groundhog

CHAPTER 110
TRAPPING LIMITATIONS

- 110.1(481A) Public roadside limitations—snares, body-gripping, and conibear type traps
- 110.2(481A) Snares
- 110.3(481A) Body-gripping and conibear type traps
- 110.4(481A) Foothold and leghold traps
- 110.5(481A) Removal of animals from traps and snares
- 110.6(481A) Trap tag requirements
- 110.7(481A) Colony traps

CHAPTER 111
SCIENTIFIC COLLECTING AND WILDLIFE REHABILITATION

- 111.1(481A) Definitions
- 111.2(481A) Scientific collector's license
- 111.3(481A) Wildlife salvage permit
- 111.4(481A) Educational project permit
- 111.5(481A) Wildlife rehabilitation permit
- 111.6(481A) Application qualifications
- 111.7(481A) Evaluation committee
- 111.8(481A) Disposition of animals
- 111.9(481A) General conditions for permits

CHAPTER 112
HUNTING PRESERVES

- 112.1(484B) Definitions
- 112.2(484B) Hunting preserve operator's license
- 112.3(484B) Land leases required
- 112.4(484B) Boundary signs required
- 112.5(484B) Fencing required—ungulates

112.6(484B)	Records and annual report
112.7(484B)	Game bird transportation tags
112.8(484B)	Ungulate transportation tags
112.9(484B)	Processed game birds
112.10(484B)	Processed ungulates
112.11(484B)	Health requirements—game birds and ungulates
112.12(484B)	General conditions for permits

CHAPTER 113

RESTITUTION FOR POLLUTION CAUSING INJURY TO WILD ANIMALS

113.1(481A)	Applicability
113.2(481A)	Definitions
113.3(481A)	Liability to the state
113.4(481A)	Assessment
113.5(481A)	Compensation

CHAPTER 114

NUISANCE WILDLIFE CONTROL

114.1(456A)	Nuisance wildlife control program
114.2(456A)	Definitions
114.3(456A)	Nuisance wildlife control operator's permit
114.4(456A)	Application requirements
114.5(456A)	Nuisance wildlife control operator's guidebook
114.6(456A)	Nuisance wildlife control operator's test and interview
114.7(456A)	Records and record-keeping requirements
114.8(456A)	Annual activity report
114.9(456A)	Permit renewal
114.10(456A)	Helper
114.11(456A)	Capture methods and trap tagging
114.12(456A)	Endangered and threatened wildlife species
114.13(456A)	Special Canada goose control permits
114.14(456A)	Disposition of captured nuisance wildlife
114.15(456A)	General conditions for permits
114.16(456A)	Permit refusal
114.17(456A)	Penalties

CHAPTER 115

WHITETAIL HUNTING PRESERVES

115.1(81GA,SF206)	Definitions
115.2(81GA,SF206)	Hunting preserve operator's registration
115.3(81GA,SF206)	Boundary signs required
115.4(81GA,SF206)	Fencing required
115.5(81GA,SF206)	Records and annual report
115.6(81GA,SF206)	Whitetail transportation tags
115.7(81GA,SF206)	Processed whitetail
115.8(81GA,SF206)	Health requirements—whitetail
115.9(81GA,SF206)	Chronic wasting disease testing
115.10(81GA,SF206)	Positive chronic wasting disease test results
115.11(81GA,SF206)	General conditions for registration

CHAPTER 116

HELP US STOP HUNGER PROGRAM ADMINISTRATION

- 116.1(483A) Purpose
- 116.2(483A) Definitions
- 116.3(483A) Restrictions
- 116.4(483A) HUSH council
- 116.5(483A) Duties of the department
- 116.6(483A) Duties of venison distributor
- 116.7(483A) Meat processors
- 116.8(483A) Partnerships with other organizations

TITLE II
LICENSES, PERMITS AND
CONCESSION CONTRACTS

CHAPTER 14
CONCESSIONS

571—14.1(461A) Definitions.

“*Concessionaire*” means person or firm granted a contract to operate a concession in a state park or recreation area. The concessionaire is an independent contractor and not an employee or agent of the department.

“*Concession operation*” means operating a business within a concession area in a state park or recreation area including, but not limited to, boat rental, snack food sales, beach operation, and sale of fishing bait and tackle.

“*Department*” means department of natural resources.

“*Director*” means the director of the department of natural resources.

“*Friends group or organization*” means an organization incorporated under Iowa Code chapter 504 as a not-for-profit group which has been formed solely for the purpose of promoting and enhancing a particular state park, recreation area, or the Iowa state park system, or any combination of the three.

“*Gross receipts*” means the total amount received, excluding sales tax, realized by or accruing to the concessionaire from all sales, for cash or credit, of services, accommodations, materials, or other merchandise pursuant to rights granted in the contract including gross receipts of subconcessionaires. All moneys paid into coin-operated devices, except telephones, shall be included in gross receipts.

“*New concession*” means the right to concession operation in an area that does not currently have a concessionaire or an area where the department wishes to invite bids for a mobile type concession operation.

“*Newspaper*” is as defined in Iowa Code section 618.3.

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.2(461A) Advertising or notice procedure.

14.2(1) *New concession.*

a. Advertising. When the department desires to obtain a new concession operation to offer multiple concession services in an area, the department shall advertise the request for proposals on the targeted small business Web site at <http://www.iowalifechanging.com/business/tsb/tsbsearchlogin.asp> and the department’s requests for proposals Web site at <http://www.iowadnr.gov/rfp.html>. The department shall advertise a notice for the request for proposals in one newspaper of statewide circulation and in at least one newspaper designated by the county to be used for official publications in the county in which the state park or recreation area is located.

b. The notice shall state the following:

- (1) The names and location of the area(s) in which concession operations are available.
- (2) The general types of services the department would expect a concessionaire to furnish.
- (3) Information regarding how to obtain the request for proposals information.
- (4) The deadline for submission of proposals to the department.

c. The department shall allow a minimum of 15 days between the date of publication of advertisements and the deadline for submission of proposals.

d. The request for proposals shall include the following information:

(1) A scope of work that contains detailed information regarding the types of services expected to be offered by the concessionaire and the history of the gross receipts reported for the previous five operating years by the prior concessionaire (if applicable); bid terms acceptable to the department; the name, address, and telephone number of the person to contact regarding the request for proposals; and the date and time by which the proposals must be received by the department.

(2) A map of the park in which the concession operation is proposed.

(3) A sample of the contract the successful bidder will be expected to sign.

(4) Samples of report forms that the concessionaire must submit to the department while the concession is in operation.

14.2(2) *Renewal of existing concession operation.*

a. The department may, at its option, mutually agree with the concessionaire to renew a contract during or at the end of its term. A concessionaire may request renewal during the term of a contract after a minimum three years of concession operation and a minimum of six months prior to expiration of the existing contract. The provisions of the renewal contract shall be negotiated between the department and the concessionaire. Should either party choose not to renew the contract, appropriate notice shall be sent to the other party four months prior to the expiration date of the existing contract, and the department may advertise for bids in accordance with this chapter.

b. The department shall publish a notice of intent to renew a concession contract that has been negotiated in accordance with paragraph 14.2(2)“*a.*” The notice shall be published in the same manner as provided in paragraph 14.2(1)“*a.*” and shall solicit public comments regarding the renewal.

c. The department director shall, upon review of comments received, determine whether to solicit bids or proceed with the renewal of the existing contract and shall notify the concessionaire of the decision in writing. If the director denies the renewal request, the existing concessionaire may request a contested case proceeding pursuant to Iowa Code chapter 17A.

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.3(461A) Bidding process.

14.3(1) *Proposals.* Persons interested in operating a concession in a state park or recreation area shall submit a proposal in the format requested in the request for proposals. It is the bidder’s responsibility to inspect the area proposed for concession operation and be fully aware of the condition and physical layout of the area. The proposal shall also include an explanation of any proposed operation not mentioned in the request for proposals. Concession facilities shall be bid on an “as is” basis unless the department agrees in writing to undertake certain improvements.

a. The department reserves the right to reject any or all bids.

b. If no bids are received for a concession operation, the department may:

(1) Readvertise for bids; or

(2) Contact interested persons and attempt to negotiate a contract; or

(3) Determine that there will be no concession operation in that particular area that year.

14.3(2) *Vending machines.*

a. Placement of vending machines in state parks and recreation areas shall not be subject to the advertising and bidding process established by this chapter.

b. Vending machines may be placed in state parks and recreation areas only by the publisher or distributor of the newspaper to be sold, the distributor of the soft drink to be sold in the machines, or by private vending machine companies.

c. Companies placing vending machines in state parks and recreation areas must submit a proposal to the department that states the location, number, and type of vending machines to be placed; the price(s) that will be charged to the public; and the proposed fee or commission to be paid to the state.

d. Any fees or commissions to be paid by the vendor to the state shall be paid directly to the department’s central office in Des Moines, Iowa.

e. The department will not install new electrical lines, concrete pads, or any other items needed to enable installation of vending machines.

14.3(3) *Firewood sales.*

a. Firewood sales contracts shall not be subject to the advertising and bidding process established by this chapter.

b. Persons interested in selling firewood in a state park or recreation area that has no other concessionaire, or if the concessionaire has declined the opportunity to sell firewood, shall submit a request to the department that identifies the area(s) where the firewood would be sold, the price to be charged to the public, and the proposed fee or commission to be paid to the state.

c. All firewood sold or distributed in state parks and recreation areas shall be accompanied with a firewood label that meets labeling requirements identified in 21—46.16(177A).

d. All firewood that originates from a quarantined area and that is sold or distributed in state parks and recreation areas must be certified by the United States Department of Agriculture to show that the firewood has been processed or treated according to applicable federal regulations.

14.3(4) Friends group or organization.

a. Concession contracts with a friends group or organization, as defined in 571—14.1(461A), in state parks and recreation areas shall not be subject to the advertising and bidding process established by this chapter.

b. A friends group or organization shall submit a proposal to operate a concession operation at a particular state park or recreation area. The proposal shall state the services to be provided, the proposed hours of operation, and proposed staffing.

c. All net proceeds from the sale of merchandise and other concession services shall be spent on state park or recreation area improvement projects.

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.4(461A) Selection of a concessionaire. The department shall select the concessionaire it determines to be best suited for a concession operation in a state park or recreation area upon evaluation of the following information:

1. The services proposed in the concession operation, including whether foods and drinks recommended by the most current version of the Iowa department of public health's "Comprehensive Nutrition and Physical Activity Plan" are being offered.

2. The concessionaire's managerial experience and other concession-related experience.

3. The concessionaire's financial stability, based upon a review of the concessionaire's existing profitability, equity, available cash, and other applicable financial data.

4. The annual lease payment bid.

5. The length of contract proposed (five-year maximum).

6. A check of all business and personal references given in the proposal.

7. The use of environmentally friendly practices and materials including, but not limited to, participation in recycling programs, use of items that contain recycled-content materials, use of energy-efficient appliances and equipment, and light pollution reduction.

8. The results of a criminal background check, driver's license record check, and child abuse registry check.

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.5(461A) Concession contract—general. The term of the concession contract shall be for no more than a five-year period without being subject to the renewal process as outlined in this chapter. The contract may be amended during its term, in writing, and effective only if the amendments are approved by all parties.

14.5(1) Construction. The contract may allow the construction of department-approved buildings or other facilities by the concessionaire in lieu of annual concession fee payments on an equal value basis. The value of the buildings or facilities shall be based on actual, documented cost of construction. Any structures built under this contract condition shall become state property and cannot be removed by the concessionaire unless removal is required by the contract.

14.5(2) Insurance. Insurance coverage required to be carried by the concessionaire shall be "occurrence" type rather than "claims made."

14.5(3) Exclusive rights. The contract gives the concessionaire exclusive rights to conduct the concession operation in a particular state park or recreation area. The concessionaire must have department approval prior to allowing other vendors to do business in the area under the terms of the contract. This provision does not prohibit the department from allowing other vendors in an area if the department identifies a service that is not under contract with the concessionaire and the concessionaire declines to provide that service.

14.5(4) Temporary authorization. If necessary, the department director shall have authority to issue a temporary letter of authorization to enable the successful bidder to operate a concession pending approval of the contract by the commission if commission approval is required by statute. The letter of authorization will incorporate all stipulations and conditions of the contract. The term of the letter of authorization shall not exceed 90 calendar days from the date of issuance.

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.6(461A) Dispute resolution. Should a dispute arise between the concessionaire and the department as to the interpretation of contract stipulations or whether the concessionaire is performing satisfactorily, the initial step for resolving the dispute will be an informal meeting and discussion between the park staff and the district parks supervisor or other department personnel in charge of the area and the concessionaire. If the matter cannot be resolved, the concessionaire or department personnel in charge of the area may request a meeting with parks bureau staff in the central office of the department. The bureau chief shall, if possible, resolve the dispute to the satisfaction of all parties. If the dispute cannot be resolved, the contract shall be terminated and the department may advertise for bids in accordance with this chapter. The requirements of Iowa Code section 17A.18(3) shall apply to any contract termination under the provisions of this rule. The provisions of this rule shall not be a bar to or prerequisite of the provisions of rule 571—14.7(461A).

[ARC 9552B, IAB 6/1/11, effective 7/6/11]

571—14.7(461A) Suspension or termination for cause.

14.7(1) Emergency suspension. If the department determines that continued operation of the concession presents an immediate hazard to the public health, safety or welfare or is in violation of any state law or policy, the department may immediately suspend the contract by notice procedures described in the contract. The notice shall contain specific reasons for the emergency suspension.

The department may enforce the suspension by physically closing the concession premises. The department may assign employees to operate any part of a concession which the department determines should be opened during a suspension in order to provide continued services for park users.

If possible, the concessionaire may take action to correct the hazardous situation and request reinstatement of the contract if the department agrees that a hazardous situation no longer exists.

14.7(2) Termination of contract. The department may terminate the contract for one or more of the following reasons:

- a. Failure to correct a hazardous condition within a reasonable time specified in the notice of emergency termination.
- b. Nonconformance with the stipulations of the contract including payment of fees.
- c. Unsatisfactory performance of the concessionaire.

Upon notice of termination of the contract, the concessionaire may request a hearing under the provisions of natural resource commission rules 571—Chapter 7.

571—14.8(461A) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

These rules are intended to implement Iowa Code sections 461A.3 and 461A.4.

[Filed 3/4/88, Notice 12/30/87—published 3/23/88, effective 4/27/88]

[Filed 1/6/89, Notice 11/30/88—published 1/25/89, effective 3/1/89]

[Filed 6/14/96, Notice 2/28/96—published 7/3/96, effective 8/7/96]

[Filed ARC 9552B (Notice ARC 9363B, IAB 2/9/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 44
SPECIAL EVENTS AND FIREWORKS DISPLAYS

[Prior to 12/31/86, Conservation Commission[290] Ch 35]
[Prior to 6/1/11, see also 571—Chs 65 and 88 and subrule 61.7(16)]

571—44.1(321G,321I,461A,462A,481A) Scope. The purpose of this chapter is to provide rules on the issuance of permits for special events and fireworks displays held on public land, waters, and ice of the state.

[ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.2(321G,321I,461A,462A,481A) Definitions. For the purposes of this chapter, the following definitions shall apply:

“Accredited postsecondary institution or program” means an institution or program listed in the U.S. Department of Education’s database of accredited postsecondary institutions and programs.

“Administrative processing fee” means the fee collected for the processing of each special event application that is submitted.

“All-terrain vehicle” or *“ATV”* means a motorized flotation-tire vehicle with not less than three and not more than six low-pressure tires that is limited in engine displacement to less than 1,000 cubic centimeters and in total dry weight to less than 1,000 pounds and that has a seat or saddle designed to be straddled by the operator and handlebars for steering control.

“Centralized special events application system” means the Web-based system used by applicants to submit applications for special events as permitted under this chapter. Approved applications shall be placed on a calendar of events Web page, accessible from the department’s homepage, to inform the general public of scheduled events on public, or when applicable, private, land, water, and ice.

“Department” means the Iowa department of natural resources.

“Field and retriever meet or trial” means an event held on either private or public land where the skill of dogs in pointing, retrieving, trailing, or chasing any game bird, game animal, or fur-bearing animal is demonstrated. For purposes of this chapter, “field and retriever meet or trial” is included in the definition of “special event” unless otherwise specified.

“Fishing tournament” means any organized fishing event, except for department-sponsored fishing events held for educational purposes, involving any of the following: (1) six or more boats or 12 or more participants, except for waters of the Mississippi River, where the number of boats shall be 20 or more and the number of participants shall be 40 or more; (2) an entry fee is charged; and (3) prizes or other inducements are awarded. For purposes of this chapter, “fishing tournament” is included in the definition of “special event” unless otherwise specified.

“Friends group” means an organization incorporated under Iowa Code chapter 504 or prior statutory authority as a not-for-profit group which has been formed solely for the purpose of promoting and enhancing a particular state park, recreation area, or the Iowa state park system, or any combination of the three.

“Off-road motorcycle” or *“ORM”* means a two-wheeled motor vehicle that has a seat or saddle designed to be straddled by the operator and handlebars for steering control and that is intended by the manufacturer for use on natural terrain. “Off-road motorcycle” includes a motorcycle that was originally issued a certificate of title and registered for highway use under Iowa Code chapter 321, but which contains design features that enable operation over natural terrain.

“Off-road utility vehicle” or *“OHV”* means a motorized flotation-tire vehicle with not less than four and not more than eight low-pressure tires that is limited in engine displacement to less than 1,500 cubic centimeters and in total dry weight to not more than 1,800 pounds and that has a seat that is of bucket or bench design, not intended to be straddled by the operator, and a steering wheel or control levers for control. A motorized vehicle that was previously titled or is currently titled under Iowa Code chapter 321 shall not be registered or operated as an off-road utility vehicle.

“Permit” means a document issued by the department that enumerates all stipulations, requirements, and contingencies that the applicant must accept and adhere to throughout the duration of the approved special event.

“*Public land*” means land under the jurisdiction of the natural resource commission.

“*Public water*” means water and ice under the jurisdiction of the natural resource commission.

“*Sailing school*” means an organization that provides basic and advanced sailing instruction by U.S. Sailing-certified instructors and is affiliated with a yacht club, an accredited postsecondary institution or program, a private or public primary or secondary school, a scouting organization, or a religious institution.

“*Snowmobile*” means a motorized vehicle weighing less than 1,000 pounds which uses sled-type runners or skis, endless belt-type tread with a width of 48 inches or less, or any combination of runners, skis, or tread and which is designed for travel on snow or ice. “Snowmobile” does not include an all-terrain vehicle, as defined in Iowa Code section 321I.1, which has been altered or equipped with runners, skis, belt-type tracks, or treads.

“*Special event*” means either of the following occurring on public land, water, or ice:

1. An organized race, tournament, exhibition, demonstration, or other planned event in which an admission fee is charged, prizes are awarded, or competition occurs between participants;
2. A planned event that, due to its nature, potential or actual size, or length, would likely adversely impact the use of the area by the public.

“*Vessel*” means every description of watercraft, other than a seaplane, used or capable of being used as a means of transportation on water or ice.

[ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

DIVISION I
SPECIAL EVENTS

571—44.3(321G,321I,461,462A,481A) Permit required. A permit is required in order to conduct a special event on any public land, water, or ice. A permit is also required for a field and retriever meet or trial held on private land.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.4(321G,321I,461A,462A,481A) Permit conditions. The department may impose permit conditions not specifically covered herein as deemed necessary to protect the resource or to ensure public safety. Such conditions shall be included in the permit issued by the department.

44.4(1) Use of concessionaire. If the state park or recreation area where a special event is being held has a concessionaire, the sale of food or drinks shall be governed pursuant to 571—Chapter 14. If a concessionaire chooses not to provide services during the special event, the event sponsor may bring in other concession operations as approved by the department.

44.4(2) Special permit conditions for fishing tournaments. In addition to permit conditions deemed necessary by rule 571—44.4(321G,321I,461A,462A,481A), the department may include some or all of the following permit conditions for fishing tournaments:

- a. Release of live fish.
- b. Fish measured to length and released from boat.
- c. Multiple weigh-ins when water temperatures exceed 70°F.
- d. Aerated live wells.
- e. Designated release areas.
- f. Designated release persons.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.5(321G,321I,461A,462A,481A) Application procedures. The following procedures shall be used to apply for a special event permit:

44.5(1) Applications shall be made and submitted through the department’s centralized special events application system.

44.5(2) Applications—when submitted.

a. Events for current year. Applications may be submitted anytime during the calendar year in which the special event is to begin but no later than 30 days prior to the special event.

b. Events for the next year. Applications for a special event that will start in the next calendar year shall not be submitted until September 1 of the current year.

44.5(3) The number of special events to be held at any area on the same day may be restricted if deemed necessary to avoid congestion within the area or to protect the resource.

44.5(4) One application form may be submitted for all events of the same type being held at the same location within a nine-day period and will be processed as a single application.

44.5(5) Submission of an application does not guarantee issuance of a permit.

44.5(6) Permits are nontransferable.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.6(321G,321I,462A) Alternate dates for snowmobile, boating, all-terrain vehicle, off-highway vehicle, and off-road motorcycle special events. An applicant may submit and the department may approve both a primary date and an alternate date for snowmobile, boating, ATV, ORM, and OHV special events. However, if both a primary date and an alternate date are approved, the primary date shall be used unless circumstances beyond the control of the applicant prevent its use. If the alternate date must be used for the event, the applicant shall contact the program coordinator at least one week in advance of the date on which the event shall take place to obtain final approval to use the alternate date. The program coordinator shall document this approval in writing. Upon approval of an alternate date, the applicant shall notify the local conservation officer, and the program coordinator shall update the calendar of events.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.7(321G,321I,461A,462A,481A) Insurance coverage. The applicant shall secure liability insurance for the special event and shall name the department as an additional insured. Insurance information shall be available at the time the application is submitted. The applicant shall have a copy of the insurance policy available at the event location to present to department personnel if requested. These requirements shall not apply to events sponsored by a friends group. The department reserves the right to waive these requirements on a case-by-case basis.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.8(321G,321I,461A,462A,481A) Fees and exceptions. The administrative fee for processing each special event application is \$25. In the case of field and retriever meets and trials, the fee for processing each special event application is \$2. The fees are nonrefundable.

The department shall waive the administrative fee for processing special event applications for sailing schools; accredited postsecondary institutions and programs; private and public primary and secondary schools; all department-approved watercraft education courses, ATV education courses, and snowmobile education courses; fishing clinics; friends groups; and department-sponsored youth fishing days.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.9(321G,461A) Structures placed on ice during a special event. The following requirements apply to the placement, construction, or erection of structures on ice during a special event:

44.9(1) Vendor information provided on application. The applicant shall identify the names and addresses of any vendors who will be on site during the special event.

44.9(2) Owner information. The full name, street address, and city of the structure's owner shall be displayed legibly on all sides of the structure, in block letters at least four inches in height, and in a color contrasting to the background.

44.9(3) Accessibility. Structures shall not be locked when in use.

44.9(4) Reflectors. Reflectors shall be attached to all sides of the structure in such a manner to enable them to reflect light at all times from sunrise to sunset.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.10(462A) Boating special events—registration exemptions.

44.10(1) A vessel entered in a boating special event shall not be required to be registered pursuant to Iowa Code sections 462A.4 and 462A.5 but shall be labeled with an identifying number or letter that is at least four inches high and is in a color contrasting to the vessel. The identifying number or letter shall be located in a prominent spot on the exterior of the vessel, other than on the bow.

44.10(2) The sponsor of the boating special event shall maintain a list containing:

a. The names and addresses of all persons participating in the event.

b. A description of each vessel in the event. The description of each vessel shall include the identifying number or letter of the vessel as required by 44.10(1).

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.11(462A) Mississippi River or Missouri River. Upon notification and proof that a United States Coast Guard (U.S.C.G.) permit has been secured, the department shall not require a special event application for fireworks displays or boating special events on the Mississippi River or the Missouri River. The regional U.S.C.G. office issuing permits for Mississippi River and Missouri River events is located in St. Louis, Missouri. This rule does not apply to fishing tournaments.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.12(321G,321I,461A,462A,481A) Other requirements and permits. The applicant for a permit is responsible for ensuring full compliance with the requirements of Iowa Code chapters 321G, 321I, 461A, 462A, and 481A, and any other Iowa Code chapters and rules promulgated under those chapters that may be applicable to special events. The applicant shall also acquire and comply with all applicable state and local permits issued by other state and local agencies necessary to hold the special event.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.13(321G,321I,461A,462A,481A) Authority to cancel or stop a special event. If a peace officer or any department employee determines that a permit is being violated or that safety concerns warrant canceling or stopping the special event, the peace officer or department employee has the authority to cancel or stop the special event.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.14(321G,321I,461A,462A,481A) Nonexclusive use of area. Issuance of a permit does not grant the applicant exclusive use of the public land, water, or ice that is the subject of the permit unless the permit explicitly provides otherwise.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

DIVISION II
FIREWORKS DISPLAYS

571—44.15(461A) Entities eligible for permits. Permits for fireworks displays shall be issued only to qualified entities, such as political subdivisions of the state of Iowa, and to community or civic organizations, such as chambers of commerce, junior chambers of commerce (Jaycees), rotary clubs, and Elks Lodges and similar fraternal benefit associations or societies. Permits shall not be issued to

individuals. Permits are not transferable to another entity and do not relieve the sponsoring entity from obtaining any other permits required by the state or its political subdivisions.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.16(461A) Permit conditions. The department may impose permit conditions not specifically required in these rules for any fireworks display special event as deemed necessary to protect the resource or ensure public safety. Conditions shall be included in the permit that the applicant or sponsoring organization receives if the event is approved.

[ARC 8815B, IAB 6/2/10, effective 7/7/10 (See Delay note at end of chapter); ARC 9114B, IAB 10/6/10, effective 9/10/10; ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.17(461A) Application procedures. The following procedures shall be used to apply for a permit:

44.17(1) Applications shall be made and submitted through the department's centralized special events application system.

44.17(2) Applications—when submitted.

a. Events for current year. Applications may be submitted anytime during the calendar year in which the fireworks display is to begin but no later than 30 days prior to the display.

b. Events for the next year. Applications for a fireworks display that will start in the next calendar year shall not be submitted until September 1 of the current year.

44.17(3) The number of fireworks displays or other special events at any one public land, water or ice location during a given day may be restricted if deemed necessary to avoid congestion with the public or competing events and to protect the resource.

44.17(4) The applicant shall certify in the application that the fireworks display shall be conducted by a competent operator. The location of the display shall be determined by the department representative in charge of the area.

44.17(5) Submission of an application does not guarantee issuance of a permit by the department.

[ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.18(461A) Fireworks display procedures.

44.18(1) The sponsoring entity shall take adequate safety precautions to ensure that persons not actively involved in conducting the display remain a safe distance from the firing area and any areas containing set pieces.

44.18(2) The department representative in charge of the area in which the display is conducted or any state peace officer may halt any display when the character, location, weather, or firing of the display makes it hazardous to property or dangerous to any person.

44.18(3) Any fireworks that remain unfired after the display is concluded shall be immediately disposed of by the operator or the sponsoring entity in a manner that is safe for the particular type of fireworks.

44.18(4) The sponsoring entity shall make arrangements for firefighting equipment and emergency medical services to be on the scene at all times during the firing of the display.

44.18(5) The sponsoring entity is totally responsible for cleanup of the fireworks display site at the conclusion of the display.

[ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.19(461A) Fees. A nonrefundable administrative fee of \$25 shall be charged for processing each fireworks display application.

[ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.20(461A) Insurance. The sponsoring entity for a fireworks display shall provide proof of liability insurance naming the applicant and the department as an additional insured in the sum of not less than \$1 million. The department may, at its discretion, require a greater amount. Insurance information shall be available at the time the application is submitted.

[ARC 9539B, IAB 6/1/11, effective 7/6/11]

571—44.21(461A) Concessions. If the state park or recreation area has a concessionaire on site, sales of food and other items during the display shall be governed pursuant to 571—Chapter 14. If a concessionaire chooses not to provide services during the event, the sponsoring entity may then bring in other concession operations as approved by the department.

[ARC 9539B, IAB 6/1/11, effective 7/6/11]

These rules are intended to implement Iowa Code sections 321G.16, 321I.17, 461A.3, 461A.4, 461A.42, 461A.47, 461A.57, 462A.16, 481A.22, and 481A.38.

[Filed 11/2/84, Notice 9/26/84—published 11/21/84, effective 1/1/85]

[Filed without Notice 12/12/86—published 12/31/86, effective 2/4/87]

[Filed ARC 8815B (Notice ARC 8462B, IAB 1/13/10), IAB 6/2/10, effective 7/7/10]¹

[Editorial change: IAC Supplement 6/30/10]

[Filed Emergency ARC 9114B, IAB 10/6/10, effective 9/10/10]

[Filed ARC 9539B (Notice ARC 9419B, IAB 3/9/11), IAB 6/1/11, effective 7/6/11]

¹ July 7, 2010, effective date of ARC 8815B delayed for 70 days by the Administrative Rules Review Committee at its meeting held June 8, 2010.

TITLE VI
PARKS AND RECREATION AREAS
CHAPTER 61
STATE PARKS AND RECREATION AREAS
[Prior to 12/31/86, Conservation Commission[290] Ch 45]

571—61.1(461A) Applicability. This chapter is applicable to all state-owned parks and recreation areas managed by the department of natural resources and by political subdivisions unless otherwise noted.

571—61.2(461A) Definitions.

“Bank” or *“shoreline”* means the zone of contact of a body of water with the land and an area within 25 feet of the water’s edge.

“Basic unit” or *“basic camping unit”* means the portable shelter used by one to six persons.

“Beach” is as defined in rule 571—64.1(461A).

“Beach house open shelter” means a building located on the beach which is open on two or more sides and which may or may not have a fireplace.

“Cabin” means a small, one-story dwelling of simple construction which is available for rental on a daily or weekly basis.

“Call center” means a phone center where operators process all telephone reservations, reservation changes and reservation cancellations for camping and rental facilities.

“Camping” means the erecting of a tent or shelter of natural or synthetic material or placing a sleeping bag or other bedding material on the ground or parking a motor vehicle, motor home, or trailer for the apparent purpose of overnight occupancy.

“Centralized reservation system” means a system that processes reservations using more than one method to accept reservations. Each method simultaneously communicates to a centralized database at a reservation contractor location to ensure that no campsite or rental facility is booked more than once.

“Chaperoned, organized youth group” means a group of persons 17 years of age and under, which is sponsored by and accompanied by adult representatives of a formal organization including, but not limited to, the Boy Scouts of America or Girl Scouts of America, a church, or Young Men’s or Young Women’s Christian Association. “Chaperoned, organized youth group” does not include families of members of a formal organization.

“Fishing” means taking or attempting to take fish by utilizing hook, line and bait as defined in Iowa Code section 481A.72, or use of permitted devices for taking rough fish as determined by Iowa Code sections 461A.42 and 481A.76.

“Free climbing” means climbing with the use of hands and feet only and without the use of ropes, pins and other devices normally associated with rappelling and rock climbing.

“Group camp” means those camping areas at Dolliver Memorial State Park, Springbrook State Park and Lake Keomah State Park where organized groups (i.e., family groups or youth groups) may camp. Dining hall facilities are available.

“Immediate family” means spouses, parents or legal guardians, domestic partners, dependent children and grandparents.

“Lodge” means a day-use building which is enclosed on all four sides and may have kitchen facilities such as a stove or refrigerator and which is available for rent on a daily basis. “Lodge” does not include buildings that are open on two or more sides and that contain fireplaces only.

“Modern area” means a camping area which has showers and flush toilets.

“Nonmodern area” means a camping area in which no showers are provided and which contains only pit-type latrines or flush-type toilets. Potable water may or may not be available to campers.

“Open shelter” means a building which is open on two or more sides and which may or may not include a fireplace.

“Open shelter with kitchenette” means a building which is open on two or more sides and contains a lockable, enclosed kitchen area.

“Organized youth group campsite” means a designated camping area within or next to the main campground where chaperoned, organized youth groups may camp.

“Persons with disabilities parking permit” means an identification device bearing the international symbol of accessibility that is issued by the Iowa department of transportation or similar devices that are issued by other states. The device can be a hanging device or on a motor vehicle as a plate or sticker as provided in Iowa Code section 321L.2 or 321L.9.

“Person with physical disability” means an individual, commonly termed a paraplegic or quadriplegic, with paralysis or a physical condition of the lower half of the body with the involvement of both legs, usually due to disease or injury to the spinal cord; a person who is a single or double amputee of the legs; or a person with any other physical affliction which makes it impossible to ambulate successfully in park or recreation area natural surroundings without the use of a wheeled conveyance.

“Possession” means exercising dominion or control with or without ownership over property.

“Prohibited activity” means any activity other than fishing as defined in this chapter including, but not limited to, picnicking and camping.

“Property” means personal property such as goods, money, or domestic animals.

“Recreation areas” means the following areas that have been designated by action of the natural resource commission:

<u>Area</u>	<u>County</u>
Badger Creek Recreation Area	Madison
Brushy Creek Recreation Area	Webster
Claire Wilson Park	Dickinson
Emerson Bay and Lighthouse	Dickinson
Fairport Recreation Area	Muscatine
Lower Gar Access	Dickinson
Marble Beach	Dickinson
Mines of Spain Recreation Area	Dubuque
Pioneer Recreation Area	Mitchell
Pleasant Creek Recreation Area	Linn
Templar Park	Dickinson
Volga River Recreation Area	Fayette
Wilson Island Recreation Area	Pottawattamie

These areas are managed for multiple uses, including public hunting, and are governed by rules established in this chapter as well as in 571—Chapters 52 and 105.

“Refuse” means trash, garbage, rubbish, waste papers, bottles or cans, debris, litter, oil, solvents, liquid or solid waste or other discarded material.

“Rental facilities” means those facilities that may be rented on a daily or nightly basis and includes open shelters, open shelters with kitchenettes, beach house open shelters, lodges, cabins, yurts and group camps.

“Reservation transaction fees” means fees as given in this chapter to process a reservation, change a reservation or cancel a reservation.

“Reservation window” means a rolling period of time in which a person may reserve a campsite or rental facility.

“Scuba diving” means swimming with the aid of self-contained underwater breathing apparatus.

“State park” means the following areas managed by the state and designated by action of the natural resource commission:

<u>Area</u>	<u>County</u>
A. A. Call	Kossuth
Backbone	Delaware
Banner Lakes at Summerset	Warren
Beed's Lake	Franklin
Bellevue	Jackson
Big Creek	Polk
Black Hawk	Sac
Cedar Rock	Buchanan
Clear Lake	Cerro Gordo
Dolliver Memorial	Webster
Elinor Bedell	Dickinson
Elk Rock	Marion
Fort Atkinson	Winneshiek
Fort Defiance	Emmet
Geode	Henry and Des Moines
George Wyth	Black Hawk
Green Valley	Union
Gull Point	Dickinson
Honey Creek	Appanoose
Lacey-Keosauqua	Van Buren
Lake Ahquabi	Warren
Lake Anita	Cass
Lake Darling	Washington
Lake Keomah	Mahaska
Lake Macbride	Johnson
Lake Manawa	Pottawattamie
Lake of Three Fires	Taylor
Lake Wapello	Davis
Ledges	Boone
Lewis and Clark	Monona
Maquoketa Caves	Jackson
McIntosh Woods	Cerro Gordo
Mini-Wakan	Dickinson
Nine Eagles	Decatur
Okamanpedan	Emmet
Palisades-Kepler	Linn
Pikes Peak	Clayton
Pikes Point	Dickinson
Pilot Knob	Winnebago
Pine Lake	Hardin
Prairie Rose	Shelby
Preparation Canyon	Monona
Red Haw	Lucas
Rice Lake	Winnebago

<u>Area</u>	<u>County</u>
Rock Creek	Jasper
Shimek Forest Campground	Lee
Springbrook	Guthrie
Stephens Forest Campground	Lucas
Stone	Plymouth and Woodbury
Trapper's Bay	Dickinson
Twin Lakes	Calhoun
Union Grove	Tama
Viking Lake	Montgomery
Walnut Woods	Polk
Wanata	Clay
Wapsipinicon	Jones
Waubonsie	Fremont
Wildcat Den	Muscatine
Yellow River Forest Campground	Allamakee

Use and management of these areas are governed by Iowa Code chapter 461A and by other restrictions prescribed on area signs pursuant to Iowa Code section 461A.44.

"State park managed by a management company" means the following area established by Iowa Code chapter 463C:

<u>Area</u>	<u>County</u>
Honey Creek Resort State Park	Appanoose

Use and management of this area are governed by rules established in this chapter, as well as by the indenture of trust entered into by and among the department, the treasurer of state, the Honey Creek Premiere Destination Park bond authority as established by Iowa Code chapter 463C, and Banker's Trust Corporation, dated October 1, 2006.

"State park managed by another governmental entity" means the following areas designated by action of the natural resource commission:

<u>Area</u>	<u>County</u>
Bobwhite	Wayne
Browns Lake-Bigelow Park	Woodbury
Cold Springs	Cass
Crystal Lake	Hancock
Eagle Lake	Hancock
Echo Valley	Fayette
Frank A. Gotch	Humboldt
Galland School	Lee
Heery Woods	Butler
Kearny	Palo Alto
Lake Cornelia	Wright
Lake Odessa Campground	Louisa
Margo Frankel Woods	Polk
Mill Creek	O'Brien
Oak Grove	Sioux

<u>Area</u>	<u>County</u>
Oakland Mills	Henry
Pammel	Madison
Pioneer	Mitchell
Sharon Bluffs	Appanoose
Silver Lake	Delaware
Spring Lake	Greene
Swan Lake	Carroll

Use and management of these areas are governed by Iowa Code chapter 461A, by this chapter, and by rules adopted by the managing entity.

“*State preserve*” means the following areas or portion of the areas dedicated by actions pursuant to Iowa Code section 465C.10:

<u>Area</u>	<u>County</u>
A. F. Miller	Bremer
Ames High Prairie	Story
Anderson Prairie	Emmet
Behrens Ponds and Woodland	Linn
Berry Woods	Warren
Bird Hill	Cerro Gordo
Bixby	Clayton
Bluffton Fir Stand	Winneshiek
Brush Creek Canyon	Fayette
Brushy Creek	Webster
Cameron Woods	Scott
Casey’s Paha	Tama
Catfish Creek	Dubuque
Cayler Prairie	Dickinson
Cedar Bluffs Natural Area	Mahaska
Cedar Hills Sand Prairie	Black Hawk
Cheever Lake	Emmet
Clay Prairie	Butler
Claybanks Forest	Cerro Gordo
Coldwater Cave	Winneshiek
Crossman Prairie	Howard
Decorah Ice Cave	Winneshiek
Derald Dinesen Prairie	Shelby
Doolittle Prairie	Story
Eureka Woods	Greene
Fallen Rock	Hardin
Fish Farm Mounds	Allamakee
Five Ridge Prairie	Plymouth
Fleming Woods	Poweshiek
Fort Atkinson	Winneshiek
Fossil and Prairie Park	Floyd
Freda Haffner Kettlehole	Dickinson

<u>Area</u>	<u>County</u>
Gitchie Manitou	Lyon
Hanging Bog	Linn
Hardin City Woodland	Hardin
Hartley Fort	Allamakee
Hartman Bluff	Black Hawk
Hayden Prairie	Howard
Hoffman Prairie	Cerro Gordo
Indian Bluffs Primitive Area	Jones
Indian Fish Trap	Iowa
Kalsow Prairie	Pocahontas
Kish-Ke-Kosh Prairie	Jasper
Lamson Woods	Jefferson
Liska-Stanek Prairie	Webster
Little Maquoketa River Mounds	Dubuque
Malanaphy Springs	Winneshiek
Malchow Mounds	Des Moines
Manikowski Prairie	Clinton
Mann Wilderness Area	Hardin
Marietta Sand Prairie	Marshall
Mericle Woods	Tama
Merrill A. Stainbrook	Johnson
Merritt Forest	Clayton
Montauk	Fayette
Mossy Glen	Clayton
Mount Pisgah Cemetery	Union
Mount Talbot	Woodbury and Plymouth
Nestor Stiles Prairie	Cherokee
Ocheyedan Mound	Osceola
Old State Quarry	Johnson
Palisades-Dows	Linn
Pecan Grove	Muscatine
Pellett Memorial Woods	Cass
Pilot Grove	Iowa
Pilot Knob	Hancock
Retz Memorial Woods	Clayton
Roberts Creek	Clayton
Rock Creek Island	Cedar
Rock Island Botanical	Linn
Roggman Boreal Slopes	Clayton
Rolling Thunder Prairie	Warren

<u>Area</u>	<u>County</u>
Savage Woods	Henry
Searryl's Cave	Jones
Sheeder Prairie	Guthrie
Silver Lake Fen	Dickinson
Silvers-Smith Woods	Dallas
Slinde Mounds	Allamakee
St. James Lutheran Church	Winneshiek
Starr's Cave	Des Moines
Steele Prairie	Cherokee
Stinson Prairie	Kossuth
Strasser Woods	Polk
Sylvan Runkel	Monona
Toolesboro Mounds	Louisa
Turin Loess Hills	Monona
Turkey River Mounds	Clayton
White Pine Hollow	Dubuque
Williams Prairie	Johnson
Wittrock Indian Village	O'Brien
Woodland Mounds	Warren
Woodman Hollow	Webster
Woodthrush Woods	Jefferson

Use and management of these areas are governed by rules established in this chapter as well as by management plans adopted by the preserves advisory board.

“*Swim*” or “*swimming*” means to propel oneself in water by natural means, such as movement of limbs, and includes but is not limited to wading and the use of inner tubes or beach toy-type swimming aids.

“*Walk-in camper*” means a person arriving at a campground without a reservation and wishing to occupy a first-come, first-served campsite or unrented, reservable campsite.

“*Yurt*” means a one-room circular fabric structure built on a platform which is available for rental on a daily or weekly basis.

[ARC 8821B, IAB 6/2/10, effective 7/7/10; ARC 9541B, IAB 6/1/11, effective 7/6/11]

571—61.3(461A) Establishment of centralized reservation system operating procedures and policies. The department shall establish a centralized reservation system to accept and process reservations for camping and rental facilities in state parks, recreation areas and state forest campgrounds.

61.3(1) *Centralized reservation system business rules manual.* The department shall adopt by reference the manual titled “Centralized Reservation System Business Rules for Iowa State Parks, Recreation Areas and State Forests,” dated January 1, 2006, which sets procedures and policies for the administration of reservations of campsites and rental facilities through the centralized reservation system.

61.3(2) *Recreation facilities available on centralized reservation system.*

a. Rental facilities. All rental facilities will be available on the centralized reservation system with the exception of the group camp at Springbrook State Park.

b. Campgrounds.

(1) All campgrounds will be available on the centralized reservation system except for the campgrounds at A. A. Call State Park, Fort Defiance State Park and Preparation Canyon State Park and the backpack campsites located in state forests.

(2) No less than 50 percent and up to no more than 75 percent of the total number of campsites in each individual campground shall be designated as reservable sites on the reservation system. The determination of which campsites shall be included in the reservable designation shall be the responsibility of the park staff in each park. Park staff shall include a combination of electric, nonelectric and sewer/water sites while taking into consideration campsite characteristics such as location, shade and size. The department will review the percentage of reservable sites and usage on a biennial basis and determine whether the percentage of reservable campsites should be changed. A reservable campsite will be identified with a reservable site marker on the campsite post.

(3) All designated organized youth group campsites and campsites marked with the international symbol of accessibility shall be included in the reservation system.

61.3(3) *Methods available to make reservations.* Persons may make reservations by telephone through the call center or through the Internet using the reservation system Web site.

61.3(4) *Reservation transaction fees.*

a. Reservation fee. A nonrefundable reservation fee shall be charged for each reservation made per campsite or rental facility regardless of the length of stay. The one-time fee is per reservation and is not charged per day or night. This fee is in addition to the camping fees or rental fees established in subrules 61.4(1) and 61.5(1). The reservation fee varies depending upon the method used when the reservation is made.

(1) Internet reservation — \$4.

(2) Telephone reservation — \$6.

b. Change fee. A fee shall be charged to change an existing reservation.

(1) Reservation change made through the Internet — \$5.

(2) Reservation change made over the telephone — \$7.

c. Cancellation fee. A fee shall be charged to cancel a reservation.

(1) Reservation cancellation made through the Internet — \$5.

(2) Reservation cancellation made over the telephone — \$7.

61.3(5) *Reservation window.*

a. Camping. The reservation window for campsite reservations is 3 months to 2 days prior to the arrival date.

b. Rental facilities.

(1) Rentals for May 1 to September 30. The reservation window for rental facilities is 12 months to 4 days prior to the arrival date.

(2) Rentals for October 1 to April 30. The reservation window for rental facilities is 12 months to 7 days prior to the arrival date.

[ARC 9324B, IAB 1/12/11, effective 2/16/11]

571—61.4(461A) Camping.

61.4(1) *Fees.* The following are maximum per-night fees for camping in state parks and recreation areas. The fees may be reduced or waived by the director for special events or special promotional efforts sponsored by the department of natural resources. Special events or promotional efforts shall be conducted so as to give all park facility users equal opportunity to take advantage of reduced or waived fees. Reductions or waivers shall be on a statewide basis covering like facilities. In the case of promotional events, prizes shall be awarded by random drawing of registrations made available to all park visitors during the event. In areas subject to a local option sales tax, the camping fee shall be administratively adjusted so that persons camping in those areas will pay the same total cost applicable in other areas.

	<u>Fee</u>	<u>Sales Tax</u>	<u>Total Per Night</u>
<i>a.</i> The following fees shall be in effect from May 1 to September 30 each year.			
Nonmodern	\$ 8.49	.51	\$ 9.00
Modern	10.38	.62	11.00
<i>b.</i> The following fees shall be in effect from October 1 to April 30 each year.			
Nonmodern	5.66	.34	6.00
Modern	7.55	.45	8.00
<i>c.</i> Electricity			
	4.72	.28	5.00
This fee will be charged in addition to the camping fee on sites where electricity is available (whether it is used or not).			
<i>d.</i> Organized youth group campsite, per group	14.15	.85	15.00
<i>e.</i> Cable television hookup	1.89	.11	2.00
<i>f.</i> Sewer and water hookup	2.83	.17	3.00
<i>g.</i> Additional fee for campgrounds designated for equestrian use	2.83	.17	3.00
This fee is in addition to applicable fees listed above.			
<i>h.</i> Camping tickets (per book of seven)	85.85	5.15	91.00

Camping tickets shall be valid for one year from the month of purchase. Persons using valid camping tickets purchased prior to any fee increase will not be required to pay the difference due to that fee increase.

61.4(2) *Varying fees.* Fees charged for like services in state-owned areas under management by political subdivisions may vary from those established by this chapter.

61.4(3) *Procedures for camping registration.*

a. Registration.

(1) Registration of walk-in campers occupying nonreservable campsites or unrented, reservable campsites will be on a first-come, first-served basis and will be handled by a self-registration process. Registration forms will be provided by the department of natural resources. Campers shall, within one-half hour of arrival at the campground, complete the registration form, place the appropriate fee or number of camping tickets in the envelope and place the envelope in the depository provided by the department of natural resources. One copy must then be placed in the campsite holder provided at the campsite.

(2) Park staff shall complete the registration of campers with reservations and place the registration in the campsite holder no later than one hour prior to check-in time on the day of the camper's arrival.

b. Campsites are considered occupied and registration for a campsite shall be considered complete when the requirements of 61.4(3) "a" have been met.

c. Campsite registration must be in the name of a person 18 years of age or older who will occupy the camping unit on that site for the full term of the registration.

d. Each camping ticket shall cover the cost of one night of camping in a modern area on a site where electricity is furnished. In addition to using the camping ticket, persons camping on equestrian sites or on sites which also have sewer and water hookups or cable television hookups available must pay the additional charges for these services. Use of a camping ticket in an area or on a site which would require a lesser fee than an electrical site in a modern area will not entitle the user to a refund or credit of any kind.

61.4(4) *Organized youth group campsite registration.*

a. Registration procedures for organized youth group campsites shall be governed by paragraphs "a," "b" and "c" of 61.4(3).

b. Chaperoned, organized youth groups may choose to occupy campsites not designated as organized youth group campsites. However, the group is subject to all fees and rules in 61.4(1), 61.4(3) and 61.4(5) pertaining to the campsite the group wishes to occupy.

61.4(5) Restrictions on campsite/campground use. This subrule sets forth conditions of public use which apply to all state parks and recreation areas. Specific areas as listed in 61.4(6), 571—61.7(461A) and 571—61.10(461A) are subject to additional restrictions or exceptions. The conditions in this subrule are in addition to specific conditions and restrictions set forth in Iowa Code chapter 461A.

a. Camping is restricted to designated camping areas within state parks and recreation areas and state forest campgrounds.

b. No more than six persons shall occupy a campsite except for the following:

(1) Families that exceed six persons may be allowed on one campsite if all members are immediate family and cannot logically be split to occupy two campsites.

(2) Campsites which are designated as chaperoned, organized youth group campsites.

c. Camping is restricted to one basic unit per site except that a small tent may be placed on a site with the basic unit. The area occupied by the small tent shall be no more than 8 feet by 10 feet and the tent shall hold no more than four people.

d. Each camping group shall utilize only the electrical outlet fixture designated for its particular campsite. No extension cords or other means of hookup shall be used to furnish electricity from one designated campsite to another.

e. Each camping group will be permitted to park one motor vehicle not being used for camping purposes at the campsite. Unless otherwise posted, one additional vehicle may be parked at the campsite.

f. All motor vehicles, excluding motorcycles, not covered by the provision in 61.4(5) "e" shall be parked in designated extra-vehicle parking areas.

g. Walk-in campers occupying nonreservable campsites or unrented, reservable campsites shall register as provided in subrule 61.4(3) within one-half hour of entering the campground.

h. Campers occupying nonreservable campsites shall vacate the campground or register for the night prior to 4 p.m. daily. Registration can be for more than 1 night at a time but not for more than 14 consecutive nights for nonreservable campsites. All members of the camping party must vacate the state park or recreation area campground after the fourteenth night and may not return to the state park or recreation area until a minimum of 3 nights has passed. All equipment must be removed from the site at the end of each stay. The 14-night limitation shall not apply to volunteers working under a department of natural resources program.

i. Walk-in campers shall not occupy unrented, reservable campsites until 10 a.m. on the first camping day of their stay. Campers shall vacate the campground by 3 p.m. of the last day of their stay. Initial registration shall not exceed 2 nights. Campers may continue to register after the first 2 nights on a night-to-night basis up to a maximum of 14 consecutive nights, subject to campsite availability. All members of the camping party must vacate the state park or recreation area campground after the fourteenth night and may not return to the state park or recreation area until a minimum of 3 nights has passed. All equipment must be removed from the site at the end of each stay. The 14-night limitation shall not apply to volunteers working under a department of natural resources program.

j. Campers with reservations shall not occupy a campsite before 4 p.m. of the first day of their stay. Campers shall vacate the site by 3 p.m. of the last day of their stay. Campers may register for more than 1 night at a time but not for more than 14 consecutive nights. All members of the camping party must vacate the state park or recreation area campground after the fourteenth night and may not return to the state park or recreation area until a minimum of 3 nights has passed. All equipment must be removed from the site at the end of each stay. The 14-night limitation shall not apply to volunteers working under a department of natural resources program.

k. Campsites marked with the international symbol of accessibility shall be used only by vehicles displaying a persons with disabilities parking permit. The vehicle must be in use by a person with a disability, either as an operator or a passenger.

l. In designated campgrounds, equine animals and llamas must be stabled at a hitching rail, individual stall or corral if provided. Equine animals and llamas may be hitched to trailers for short

periods of time to allow for grooming and saddling. These animals may be stabled inside trailers if no hitching facilities are provided. Portable stalls/pens and electric fences are not permitted.

61.4(6) Area-specific restrictions on campground use. In addition to the general conditions of public use set forth in this chapter, special conditions shall apply to specific areas listed as follows:

a. Brushy Creek Recreation Area, Webster County.

(1) In the designated equestrian campgrounds, the maximum number of equine animals to be tied to the hitching rails is six. Persons with a number of equine animals in excess of the number permitted on the hitching rail at their campsite shall be allowed to stable their additional animals in a trailer or register and pay for an additional campsite if available.

(2) In the designated equestrian campgrounds, equine animals may be tied to trailers for short periods of time to allow grooming or saddling; however, the tying of equine animals to the exterior of trailers for extended periods of time or for stabling is not permitted.

b. Recreation area campgrounds. Access into and out of designated campgrounds shall be permitted from 4 a.m. to 10:30 p.m. From 10:30 p.m. to 4 a.m., only registered campers are permitted in and out of the campgrounds.

c. Lake Manawa State Park, Pottawattamie County. Except for the following limitations on campground length of stay, campsite use restrictions as stated in 61.4(5) shall apply to Lake Manawa. Campers may register for more than 1 night at a time but not for more than 14 consecutive nights. No person may camp at the Lake Manawa campground for more than 14 nights in any 30-day period.

d. Walnut Woods State Park, Polk County. Except for the following limitations on campground length of stay, campsite use restrictions as stated in 61.4(5) shall apply to Walnut Woods. Campers may register for more than 1 night at a time but not for more than 14 consecutive nights. No person may camp at the Walnut Woods campground for more than 14 nights in any 30-day period.

61.4(7) Campground fishing. Rule 61.11(461A) is not intended to prohibit fishing by registered campers who fish from the shoreline within the camping area.

[ARC 7684B, IAB 4/8/09, effective 5/13/09; ARC 8821B, IAB 6/2/10, effective 7/7/10]

571—61.5(461A) Rental facilities. The following are maximum fees for facility use in state parks and recreation areas. The fees may be reduced or waived by the director for special events or special promotional efforts sponsored by the department of natural resources. Special events or promotional efforts shall be conducted so as to give all park facility users equal opportunity to take advantage of reduced or waived fees. Reductions or waivers shall be on a statewide basis covering like facilities. In the case of promotional events, prizes shall be awarded by random drawing of registrations made available to all park visitors during the event.

61.5(1) Fees.

a. Cabin rental. This fee does not include tax. Tax will be calculated at time of final payment.

	<u>Per Night*</u>	<u>Per Week</u>
Backbone State Park, Delaware County		
Renovated modern cabins	\$ 50	\$300
Two-bedroom modern cabins	85	510
Deluxe cabins	100	600
Black Hawk State Park, Sac County	100	600
Dolliver Memorial State Park, Webster County	35	210
Green Valley State Park, Union County	35	210
Honey Creek State Park, Appanoose County	35	210
Lacey-Keosauqua State Park, Van Buren County	50	300
Lake Darling State Park, Washington County	35	210
Lake of Three Fires State Park, Taylor County	50	300
Lake Wapello State Park, Davis County (Cabin Nos. 1-12)	60	360
Lake Wapello State Park, Davis County (Cabin No. 13)	85	510

	<u>Per Night*</u>	<u>Per Week</u>
Lake Wapello State Park, Davis County (Cabin No. 14)	75	450
Nine Eagles State Park, Decatur County	75	450
Palisades-Kepler State Park, Linn County	50	300
Pine Lake State Park, Hardin County		
Studio cabins (four-person occupancy limit)	65	390
One-bedroom cabins	75	450
Pleasant Creek State Recreation Area, Linn County	35	210
Prairie Rose State Park, Shelby County	35	210
Springbrook State Park, Guthrie County	200	1200
Stone State Park, Woodbury County	35	210
Union Grove State Park, Tama County	75	450
Waubonsie State Park, Fremont County		
Two-bedroom modern cabins	85	510
One-bedroom modern cabins	60	360
Two-bedroom camping cabins	50	300
One-bedroom camping cabins	35	210
Camping cabin	25	150
Wilson Island State Recreation Area, Pottawattamie County	25	150

*Minimum two nights

b. Yurt rental. This fee does not include tax. Tax will be calculated at time of payment.

	<u>Per Night*</u>	<u>Per Week</u>
McIntosh Woods State Park, Cerro Gordo County	\$ 35	\$210

*Minimum two nights

c. Lodge rental per reservation. This fee does not include tax. Tax will be calculated at time of payment.

	<u>Per Weekday</u> <u>M-Th***</u>	<u>Per Weekend Day</u> <u>Fr-Su</u>
A. A. Call State Park, Kossuth County	\$ 40	\$ 80
Backbone State Park Auditorium, Delaware County**	25	50
Backbone State Park, Delaware County	62.50	125
Beed's Lake State Park, Franklin County	40	80
Bellevue State Park-Nelson Unit, Jackson County	50	100
Clear Lake State Park, Cerro Gordo County	50	100
Dolliver Memorial State Park-Central Lodge, Webster County**	30	60
Dolliver Memorial State Park-South Lodge, Webster County	37.50	75
Ft. Defiance State Park, Emmet County	35	70
George Wyth State Park, Black Hawk County**	35	70
Gull Point State Park, Dickinson County	100	200
Lacey-Keosauqua State Park, Van Buren County	35	70
Lake Ahquabi State Park, Warren County	45	90
Lake Darling State Park, Washington County	100	200
Lake Keomah State Park, Mahaska County	45	90
Lake Macbride State Park, Johnson County		

	<u>Per Weekday</u> <u>M-Th***</u>	<u>Per Weekend Day</u> <u>Fr-Su</u>
Beach Lodge	35	70
Lodge	35	70
Lake of Three Fires State Park, Taylor County	35	70
Lake Wapello State Park, Davis County	30	60
Lewis and Clark State Park, Monona County	35	70
Palisades-Kepler State Park, Linn County	87.50	175
Pine Lake State Park, Hardin County	40	80
Pleasant Creek Recreation Area, Linn County**	37.50	75
Stone State Park, Woodbury/Plymouth Counties	62.50	125
Viking Lake State Park, Montgomery County	30	60
Walnut Woods State Park, Polk County	100	200
Wapsipinicon State Park, Jones County		
Heated year-round lodge	35	70
Unheated seasonal lodge	20	40

**Does not contain kitchen facilities

***The weekend day fee applies to New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, and Christmas, even though the holiday may fall on a weekday.

- d. Open shelter reservation, \$25 plus applicable tax.
- e. Reservation for open shelter with kitchen, \$75 plus applicable tax.
- f. Beach house open shelter reservation, \$40 plus applicable tax:
 Lake Ahquabi State Park, Warren County
 Lake Wapello State Park, Davis County
 Pine Lake State Park, Hardin County
 Springbrook State Park, Guthrie County
- g. Group camp rental. This fee does not include tax. Tax will be calculated at time of payment.
- (1) Dolliver Memorial State Park, Webster County. Rental includes use of restroom/shower facility at Dolliver Memorial State Park.
1. Chaperoned, organized youth groups—\$2 per day per person with a minimum charge per day of \$60.
2. Other groups—\$15 per day per cabin plus \$30 per day for the kitchen and dining facility.
- (2) Lake Keomah State Park, Mahaska County. All groups—\$40 per day for the dining/restroom facility plus the applicable camping fee. Lake Keomah dining/restroom facility day use only rental \$90.
- h. Springbrook State Park conservation education center rental. The conservation education center may be rented as a group camp facility or as an educational group facility. All rentals shall be handled through staff at the education center.
- (1) Linen service. Linen service includes bedding, pillows, towels and washcloths. The linen service fee stated below shall be charged. School groups are required to use the linen service. All other groups may elect to use the linen service.
- (2) Concessionaire. All groups that utilize the classroom building and use education center staff for programs must use the concessionaire for all meals. All other groups may elect to use the kitchenette at the fee stated below or use the concessionaire or a combination of both.
- (3) Classroom. All day use groups not utilizing the entire conservation education center facilities must pay the appropriate classroom or library fee. Overnight groups wishing to use the classroom facility for non-conservation education activities (such as quilters' meetings or family reunions) must pay the appropriate classroom fee.
- (4) Reservations. School groups and DNR camps may reserve the center three years in advance. All other groups may reserve the center a year in advance on a first-come, first-served basis. There is no reservation fee. Fees shall be paid upon arrival at the center.

(5) Damage deposit. The damage deposit shall be paid on a separate instrument from the rental fee. School groups shall be exempt from this requirement.

(6) Day use attendance fee. A fee of \$5 per person per day plus applicable tax shall be charged to all day use groups and all persons associated with overnight groups attending day functions only when they utilize the entire conservation education center facilities and staff services.

(7) Overnight rental fees. These fees do not include tax. Tax will be calculated at time of payment.

1. Kindergarten through grade 12—\$5 per person per night.

2. Adults—\$15 per person per night.

3. Families—\$160 per dorm per night.

(8) Other services. These fees do not include tax. Tax will be calculated at time of payment.

1. Linen service—\$5 per person per night.

2. Family linen service—\$160 per dorm per night.

3. Kitchenette rental—\$30 per day or night.

4. Classroom rental—\$100 per day or night.

5. Library rental—\$50 per day or night.

6. Dining hall rental, day use only—\$100 per day.

7. Dining hall with kitchenette rental, day use only—\$130 per day.

(9) Damage deposit—\$50 per visit.

(10) Check-out times for dorms.

1. Monday-Saturday, 8 a.m.

2. Sunday, 9 a.m.

61.5(2) *Varying fees.* Fees charged for like services in state-owned areas under management by political subdivisions may vary from those established by this chapter.

61.5(3) *Procedures for rental facility registration and rentals.*

a. Registrations for all rental facilities must be in the name of a person 18 years of age or older who will be present at the facility for the full term of the reservation.

b. Rental stay requirements for cabins and yurts.

(1) Except as provided in subparagraphs 61.5(3) “b”(2) and 61.5(3) “b”(3), cabin reservations must be for a minimum of one week (Friday p.m. to Friday a.m.) beginning the Friday of the national Memorial Day holiday weekend through Thursday after the national Labor Day holiday. From the Friday after the national Labor Day holiday through the Thursday before the national Memorial Day holiday weekend, cabins may be reserved for a minimum of two nights.

(2) The cabins at Dolliver Memorial State Park; the camping cabins at Pleasant Creek and Wilson Island State Recreation Areas and Green Valley, Honey Creek, Lake Darling and Stone State Parks; the yurts at McIntosh Woods State Park; and the group camps at Dolliver Memorial and Lake Keomah State Parks may be reserved for a minimum of two nights throughout the entire rental season.

(3) The multifamily cabin at Springbrook State Park may be reserved for a minimum of two nights throughout the entire rental season with the following exceptions:

1. From the Friday of the national Memorial Day holiday weekend through the Thursday after the national Labor Day holiday, a Friday and Saturday night stay is required for weekends.

2. A Friday, Saturday, and Sunday night stay is required for the national Memorial Day holiday and national Labor Day holiday weekends.

3. A Thursday, Friday, and Saturday night stay is required for the Fourth of July holiday if the Fourth of July occurs on a Thursday, Friday or Saturday.

4. A Friday, Saturday, and Sunday night stay is required for the Fourth of July holiday if the Fourth of July occurs on a Monday.

(4) All unreserved cabins, yurts and group camps may be rented for a minimum of two nights on a walk-in, first-come, first-served basis. No walk-in rentals will be permitted after 6 p.m.

(5) Reservations or walk-in rentals for more than a two-week stay will not be accepted for any facility.

c. Persons renting cabins, yurts or group camp facilities must check in at or after 4 p.m. on Saturday. Check-out time is 11 a.m. or earlier on Saturday.

d. Persons renting facilities listed in subparagraph 61.5(3)“*b*”(2) must check in at or after 4 p.m. on the first day of the two-night rental period. Check-out time is 11 a.m. or earlier on the last day of the two-night rental period.

e. Except by arrangement for late arrival with the park staff, no cabin, yurt or group camp reservation will be held past 6 p.m. on the first night of the reservation period if the person reserving the facility does not arrive. When arrangements for late arrival have been made, the person must appear prior to the park’s closing time established by Iowa Code section 461A.46 or access will not be permitted to the facility until 8 a.m. the following day. Arrangements must be made with the park staff if next-day arrival is to be later than 9 a.m.

f. The number of persons occupying rental cabins is limited to six in cabins which contain one bedroom or less and eight in cabins with two bedrooms. Occupancy of the studio cabins at Pine Lake and all camping cabins is limited to four persons. Occupancy of the yurts is limited to four persons.

g. Except at parks or recreation areas with camping cabins or yurts, no tents or other camping units are permitted for overnight occupancy in the designated cabin area. One small tent shall be allowed at each cabin or yurt in the designated areas and is subject to the occupancy requirements of 61.4(5)“*b*.”

h. Open shelters and beach house open shelters which are not reserved are available on a first-come, first-served basis. If the open shelters with kitchenettes are not reserved, the open shelter portions of these facilities are available on a first-come, first-served basis.

i. Except by arrangement with the park staff in charge of the area, persons renting lodge, shelter, and beach house open shelter facilities and all guests shall vacate the facility by 10 p.m.

61.5(4) Damage deposits for all rental facilities.

a. Upon arrival for the rental facility period, renters shall pay in full a damage deposit in the amount of \$50.

b. Damage deposits will be refunded only after authorized personnel inspect the rental facility to ensure that the facility and furnishings are in satisfactory condition.

c. If it is necessary for department personnel to clean up the facility or repair any damage beyond ordinary wear and tear, a log of the time spent in such cleanup or repair shall be kept. The damage deposit refund shall be reduced by an amount equivalent to the applicable hourly wage of the employees for the time necessary to clean the area or repair the damage and by the cost of any repairs of furnishings.

d. The deposit is not to be construed as a limit of liability for damage to state property. The department may take legal action necessary to recover additional damages.

[ARC 7684B, IAB 4/8/09, effective 5/13/09; ARC 9186B, IAB 11/3/10, effective 12/8/10]

571—61.6(461A) Vessel storage fees. These fees do not include tax.

<u>Vessel Storage Space (wet or dry)</u>	<u>Maximum Fee</u>
Pontoon boats—eight months or less	\$150
Eight months or less (new docks)	200
Year-round	200
Year-round (new docks)	250
Other boats—eight months or less	125
Eight months or less (new docks)	150
Year-round	150
Year-round (new docks)	200

571—61.7(461A) Restrictions—area and use. This rule sets forth conditions of public use which apply to all state parks and recreation areas. Specific areas as listed in 61.4(6), 61.8(461A) and 61.11(461A) are subject to additional restrictions or exceptions. The conditions in this rule are in addition to specific conditions and restrictions set forth in Iowa Code chapter 461A.

61.7(1) Animals.

a. The use of equine animals and llamas is limited to roadways or to trails designated for such use.

- b.* Animals are prohibited within designated beach areas.
- c.* Livestock are not permitted to graze or roam within state parks and recreation areas. The owner of the livestock shall remove the livestock immediately upon notification by the department of natural resources personnel in charge of the area.
- d.* Except for dogs being used in designated hunting or in dog training areas, pets such as dogs or cats shall not be allowed to run at large within state parks, recreation areas, or preserves. Such animals shall be on a leash or chain not to exceed six feet in length and shall be either led by or carried by the owner, attached to an anchor/tie-out or vehicle, or confined in a vehicle.

61.7(2) Beach use/swimming.

a. Except as provided in paragraphs “*b*” and “*c*” of this subrule, all swimming and scuba diving shall take place in the beach area within the boundaries marked by ropes, buoys, or signs within state parks and recreation areas. Inner tubes, air mattresses and other beach-type items shall be used only in designated beach areas.

b. Persons may scuba dive in areas other than the designated beach area provided they display the diver’s flag as specified in rule 571—41.10(462A).

c. Swimming outside beach area.

(1) Persons may swim outside the beach area under the following conditions:

1. Swimming must take place between sunrise and sunset;
2. The swimmer must be accompanied by a person operating a vessel and must stay within 20 feet of the vessel at all times during the swim;
3. The vessel accompanying the swimmer must display a flag, which is at least 12-inches square, is bright orange, and is visible all around the horizon; and
4. The person swimming pursuant to this subparagraph must register with the park staff in charge of the area and sign a registration immediately prior to the swim.

(2) Unless swimming is otherwise posted as prohibited or limited to the designated beach area, a person may also swim outside the beach area provided that the person swims within ten feet of a vessel which is anchored not less than 100 yards from the shoreline or the marked boundary of a designated beach. Any vessel, except one being uprighted, must be attended at all times by at least one person remaining on board.

(3) A passenger on a sailboat or other vessel may enter the water to upright or repair the vessel and must remain within ten feet of that vessel.

d. The provisions of paragraph “*a*” of this subrule shall not be construed as prohibiting wading in areas other than the beach by persons actively engaged in shoreline fishing.

61.7(3) Bottles. Possession or use of breakable containers, the fragmented parts of which can injure a person, is prohibited in beach areas of state parks and recreation areas.

61.7(4) Chainsaws. Except by written permission of the director of the department of natural resources, chainsaw use is prohibited in state parks and recreation areas. This provision is not applicable to employees of the department of natural resources in the performance of their official duties.

61.7(5) Firearms. The use of firearms in state parks and recreation areas, as defined in 61.2(461A), is limited to the following:

a. Lawful hunting as traditionally allowed at Badger Creek Recreation Area, Brushy Creek Recreation Area, Pleasant Creek Recreation Area, Mines of Spain Recreation Area (pursuant to 61.9(461A)), Volga River Recreation Area and Wilson Island Recreation Area.

b. Target and practice shooting in areas designated by DNR.

c. Special events, festivals, and education programs sponsored or permitted by DNR.

d. Special hunts authorized by the natural resource commission to control deer populations.

61.7(6) Fishing off boat docks within state areas. Persons may fish off all state-owned docks within state parks and recreation areas. Persons fishing off these docks must yield to boats and not interfere with boaters.

61.7(7) Garbage. Using government refuse receptacles for dumping household, commercial, or industrial refuse brought as such from private property is prohibited.

61.7(8) Motor vehicle restrictions.

a. Except as provided in these rules, motor vehicles are prohibited on state parks, recreation areas and preserves except on constructed and designated roads, parking lots and campgrounds.

b. Use of motorized vehicles by persons with physical disabilities. Persons with physical disabilities may use certain motorized vehicles to access specific areas in state parks, recreation areas and preserves, according to restrictions set out in this paragraph, in order to enjoy the same recreational opportunities available to others. Allowable vehicles include any self-propelled electric or gas vehicle which has at least three wheels, but no more than six wheels, and is limited in engine displacement to less than 800 cubic centimeters and in total dry weight to less than 1,450 pounds.

(1) Permits.

1. Each person with a physical disability must have a permit issued by the director in order to use a motorized vehicle in specific areas within state parks, recreation areas, and preserves. Such permits will be issued without charge. An applicant must submit a certificate from a doctor stating that the applicant meets the criteria describing a person with a physical disability. One nonhandicapped companion may accompany the permit holder on the same vehicle if that vehicle is designed for more than one rider; otherwise the companion must walk.

2. Existing permits. Those persons possessing a valid permit for use of a motorized vehicle on game management areas as provided in 571—51.7(461A) may use a motorized vehicle to gain access to specific areas for recreational opportunities and facilities within state parks, recreation areas and preserves.

(2) Approved areas. On each visit, the permit holder must contact the park staff in charge of the specific area in which the permit holder wishes to use a motorized vehicle. The park staff must designate on a park map the area(s) where the permit holder will be allowed to use a motorized vehicle. This restriction is intended to protect the permit holder from hazards or to protect certain natural resources of the area. The map is to be signed and dated on each visit by the park staff in charge of the area. Approval for use of a motorized vehicle on state preserves also requires consultation with a member of the preserves staff in Des Moines.

(3) Exclusive use. The issuance of a permit does not imply that the permittee has exclusive or indiscriminate use of an area. Permittees shall take reasonable care not to unduly interfere with the use of the area by others.

(4) Prohibited acts and restrictions.

1. Except as provided in 61.7(8) “b,” the use of a motorized vehicle on any park, recreation area or preserve by a person without a valid permit or at any site not approved on a signed map is prohibited. Permits and maps shall be carried by the permittee at any time the permittee is using a motorized vehicle in a park, recreation area or preserve and shall be exhibited to any department employee or law enforcement official upon request.

2. The speed limit for an approved motor vehicle off-road will be no more than 5 mph. The permit of a person who is found exceeding the speed limit will be revoked.

3. The permit of any person who is found causing damage to cultural and natural features or abusing the privilege of riding off-road within the park will be revoked.

(5) Employees exempt. Restrictions in subrule 61.7(8) shall not apply to department personnel, law enforcement officials, or other authorized persons engaged in research, management or enforcement when in performance of their duties.

61.7(9) Noise. Creating or sustaining any unreasonable noise in any portion of all state parks and recreation areas is prohibited at all times. The nature and purpose of a person’s conduct, the impact on other area users, the time of day, location, and other factors which would govern the conduct of a reasonable, prudent person under the circumstances shall be used to determine whether the noise is unreasonable. Unreasonable noise shall include the operation or utilization of motorized equipment or machinery such as an electric generator, motor vehicle, or motorized toy; or audio device such as a radio, television set, tape deck, public address system, or musical instrument; or other device. Between the hours of 10:30 p.m. and 6 a.m., noise which can be heard at a distance of 120 feet or three campsites shall be considered unreasonable.

61.7(10) *Opening and closing times.* Except by arrangement or permission granted by the director or the director's authorized representative or as otherwise stated in this chapter, the following restrictions shall apply: All persons shall vacate all state parks and preserves before 10:30 p.m. each day, except authorized campers in accordance with Iowa Code section 461A.46, and no person or persons shall enter into such parks and preserves until 4 a.m. the following day.

61.7(11) *Paintball guns.* The use of any item generally referred to as a paintball gun is prohibited in state parks, recreation areas and preserves.

61.7(12) *Restrictions on picnic site use.*

a. Open picnic sites marked with the international symbol of accessibility shall be used only by a person or group with a person qualifying for and displaying a persons with disabilities parking permit on the person's vehicle.

b. Paragraph 61.7(12)“*a*” does not apply to picnic shelters marked with the international accessibility symbol. The use of the symbol on shelters shall serve only as an indication that the shelter is wheelchair accessible.

61.7(13) *Rock climbing or rappelling.* The rock climbing practice known as free climbing and climbing or rappelling activities which utilize bolts, pitons, or similar permanent anchoring equipment or ropes, harnesses, or slings are prohibited in state parks and recreation areas, except by persons or groups registered with the park staff in charge of the area. Individual members of a group must each sign a registration. Climbing or rappelling will not be permitted at Elk Rock State Park, Marion County; Ledges State Park, Boone County; Dolliver Memorial State Park, Webster County; Stone State Park, Woodbury and Plymouth Counties; Maquoketa Caves State Park, Jackson County; Wildcat Den State Park, Muscatine County; or Mines of Spain Recreation Area, Dubuque County. Other sites may be closed to climbing or rappelling if environmental damage or safety problems occur or if an endangered or threatened species is present.

61.7(14) *Speech or conduct interfering with lawful use of an area by others.*

a. Speech commonly perceived as offensive or abusive is prohibited when such speech interferes with lawful use and enjoyment of the area by another member of the public.

b. Quarreling or fighting is prohibited when it interferes with the lawful use and enjoyment of the area by another member of the public.

61.7(15) *Deer population control hunts.* Deer hunting as allowed under Iowa Code section 461A.42“*c*” is permitted only during special hunts in the following state parks as provided under 571—Chapter 105 and as approved by the natural resource commission. During the dates of deer hunting, only persons engaged in deer hunting shall use the area or portions thereof as designated by DNR and signed as such.

Backbone State Park	Delaware County
Elk Rock State Park	Marion County
George Wyth State Park	Black Hawk County
Lake Darling State Park	Washington County
Lake Manawa State Park	Pottawattamie County
Lake of Three Fires State Park	Taylor County
Springbrook State Park	Guthrie County
Viking Lake State Park	Montgomery County

61.7(16) *Special event permits.* Rescinded IAB 6/1/11, effective 7/6/11.
[ARC 7683B, IAB 4/8/09, effective 5/13/09; ARC 9541B, IAB 6/1/11, effective 7/6/11]

571—61.8(461A) Certain conditions of public use applicable to specific parks and recreation areas. In addition to the general conditions of public use set forth in this chapter, special conditions shall apply to the specific areas listed as follows:

61.8(1) *Brushy Creek State Recreation Area, Webster County.* Swimming is limited by the provisions of 61.7(2); also, swimming is prohibited at the beach from 10:30 p.m. to 6 a.m. daily.

61.8(2) *Hattie Elston Access and Claire Wilson Park, Dickinson County.*

a. Parking of vehicles overnight on these areas is prohibited unless the vehicle operator and occupants are actively involved in boating or are fishing as allowed under 61.11(461A).

b. Overnight camping is prohibited.

61.8(3) *Mines of Spain Recreation Area, Dubuque County.* All persons shall vacate all portions of the Mines of Spain Recreation Area prior to 10:30 p.m. each day, and no person or persons shall enter into the area until 4 a.m. the following day.

61.8(4) *Pleasant Creek Recreation Area, Linn County.* Swimming is limited by the provisions of 61.7(2); also, swimming is prohibited at the beach from 10:30 p.m. to 6 a.m. daily. Access into and out of the north portion of the area between the east end of the dam to the campground shall be closed from 10:30 p.m. to 4 a.m., except that walk-in overnight fishing will be allowed along the dam. The areas known as the dog trial area and the equestrian area shall be closed from 10:30 p.m. to 4 a.m., except for equestrian camping and for those persons participating in a DNR-authorized field trial. From 10:30 p.m. to 4 a.m., only registered campers are permitted in the campground.

61.8(5) *Wapsipinicon State Park, Jones County.* The land adjacent to the park on the southeast corner and generally referred to as the “Ohler property” is closed to the public from 10:30 p.m. to 4 a.m.

571—61.9(461A) Mines of Spain hunting, trapping and firearms use.

61.9(1) The following described portions of the Mines of Spain Recreation Area are established and will be posted as wildlife refuges:

a. That portion within the city limits of the city of Dubuque located west of U.S. Highway 61 and north of Mar Jo Hills Road.

b. The tract leased by the department of natural resources from the city of Dubuque upon which the E. B. Lyons Interpretive Center is located.

c. That portion located south of the north line of Section 8, Township 88 North, Range 3 East of the 5th P.M. between the west property boundary and the east line of said Section 8.

d. That portion located north of Catfish Creek, east of the Mines of Spain Road and south of the railroad tracks. This portion contains the Julien Dubuque Monument.

61.9(2) Trapping and archery hunting for all legal species are permitted in compliance with all open-season, license and possession limits on the Mines of Spain Recreation Area except in those areas designated as refuges by 61.9(1).

61.9(3) Firearms use is prohibited in the following described areas:

a. The areas described in 61.9(1).

b. The area north and west of Catfish Creek and west of Granger Creek.

61.9(4) Deer hunting and hunting for all other species are permitted using shotguns only and are permitted only during the regular gun season as established by 571—Chapter 106. Areas not described in 61.9(3) are open for hunting. Hunting shall be in compliance with all other regulations.

61.9(5) Turkey hunting with shotguns is allowed only in compliance with the following regulations:

a. Only during the first shotgun hunting season established in 571—Chapter 98, which is typically four days in mid-April.

b. Only in that area of the Mines of Spain Recreation Area located east of the established roadway and south of the Horseshoe Bluff Quarry.

61.9(6) The use or possession of a handgun or any type of rifle is prohibited on the entire Mines of Spain Recreation Area except as provided in 61.9(4). Target and practice shooting with any type of firearm is prohibited.

61.9(7) All forms of hunting, trapping and firearms use not specifically permitted by 61.9(461A) are prohibited in the Mines of Spain Recreation Area.

571—61.10(461A) After-hours fishing—exception to closing time. Persons shall be allowed access to the areas designated in 61.11(461A) between the hours of 10:30 p.m. and 4 a.m. under the following conditions:

1. The person shall be actively engaged in fishing.

2. The person shall behave in a quiet, courteous manner so as not to disturb other users of the park such as campers.
3. Access to the fishing site from the parking area shall be by the shortest and most direct trail or access facility.
4. Vehicle parking shall be in the lots designated by signs posted in the area.
5. Activities other than fishing are allowed with permission of the director or an employee designated by the director.

571—61.11(461A) Designated areas for after-hours fishing. These areas are open from 10:30 p.m. to 4 a.m. for fishing only. The areas are described as follows:

61.11(1) *Black Hawk Lake, Sac County.* The area of the state park between the road and the lake running from the marina at Drillings Point on the northeast end of the lake approximately three-fourths of a mile in a southwesterly direction to a point where the park boundary decreases to include only the roadway.

61.11(2) *Claire Wilson Park, Dickinson County.* The entire area including the parking lot, shoreline and fishing trestle facility.

61.11(3) *Clear Lake State Park, Ritz Unit, Cerro Gordo County.* The boat ramp, courtesy dock, fishing dock and parking lots.

61.11(4) *Elinor Bedell State Park, Dickinson County.* The entire length of the shoreline within state park boundaries.

61.11(5) *Elk Rock State Park, Marion County.* The Teeter Creek boat ramp area just east of State Highway 14, access to which is the first road to the left after the entrance to the park.

61.11(6) *Green Valley State Park, Union County.* The shoreline adjacent to Green Valley Road commencing at the intersection of Green Valley Road and 130th Street and continuing south along the shoreline to the parking lot on the east side of the dam, and then west along the dam embankment to the shoreline adjacent to the parking lot on the west side of the spillway.

61.11(7) *Hattie Elston Access, Dickinson County.* The entire area including the parking lot shoreline and boat ramp facilities.

61.11(8) *Honey Creek State Park, Appanoose County.* The boat ramp area located north of the park office, access to which is the first road to the left after the entrance to the park.

61.11(9) *Geode State Park, Des Moines County portion.* The area of the dam embankment that is parallel to County Road J20 and lies between the two parking lots located on each end of the embankment.

61.11(10) *Lake Keomah State Park, Mahaska County.*

a. The embankment of the dam between the crest of the dam and the lake.

b. The shoreline between the road and the lake from the south boat launch area west and north to the junction with the road leading to the group camp shelter.

61.11(11) *Lake Macbride State Park, Johnson County.* The shoreline of the south arm of the lake adjacent to the county road commencing at the “T” intersection of the roads at the north end of the north-south causeway proceeding across the causeway thence southeasterly along a foot trail to the east-west causeway, across the causeway to the parking area on the east end of that causeway.

61.11(12) *Lake Manawa State Park, Pottawattamie County.* The west shoreline including both sides of the main park road, commencing at the north park entrance and continuing south 1.5 miles to the parking lot immediately north of the picnic area located on the west side of the southwest arm of the lake.

61.11(13) *Lower Pine Lake, Hardin County.* West shoreline along Hardin County Road S56 from the beach southerly to the boat ramp access.

61.11(14) *Mini-Wakan State Park, Dickinson County.* The entire area.

61.11(15) *North Twin Lake State Park, Calhoun County.* The shoreline of the large day-use area containing the swimming beach on the east shore of the lake.

61.11(16) *Pikes Point State Park, Dickinson County.* The shoreline areas of Pikes Point State Park on the east side of West Okoboji Lake.

61.11(17) *Prairie Rose State Park, Shelby County.* The west side of the embankment of the causeway across the southeast arm of the lake including the shoreline west of the parking area located off County Road M47 and just north of the entrance leading to the park office.

61.11(18) *Rock Creek Lake, Jasper County.* Both sides of the County Road F27 causeway across the main north portion of the lake.

61.11(19) *Union Grove State Park, Tama County.*

a. The dam embankment from the spillway to the west end of the parking lot adjacent to the dam.

b. The area of state park that parallels BB Avenue, from the causeway on the north end of the lake southerly to a point approximately one-tenth of a mile southwest of the boat ramp.

61.11(20) *Upper Pine Lake, Hardin County.* Southwest shoreline extending from the boat launch ramp to the dam.

61.11(21) *Viking Lake State Park, Montgomery County.* The embankment of the dam from the parking area located southeast of the dam area northwesterly across the dam structure to its intersection with the natural shoreline of the lake.

[ARC 9186B, IAB 11/3/10, effective 12/8/10]

571—61.12(461A) Vessels prohibited. Rule 61.11(461A) does not permit the use of vessels on the artificial lakes within state parks after the 10:30 p.m. park closing time. All fishing is to be done from the bank or shoreline of the permitted area.

571—61.13(461A) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

571—61.14(461A) Restore the outdoors program. Funding provided through the appropriation set forth in Iowa Code section 461A.3A, and subsequent Acts, shall be used to renovate, replace or construct new vertical infrastructure and associated appurtenances in state parks and other public facilities managed by the department of natural resources.

The intended projects will be included in the department's annual five-year capital plan in priority order by year and approved by the natural resource commission for inclusion in its capital budget request.

The funds appropriated by Iowa Code section 461A.3A, and subsequent Acts, will be used to renovate, replace or construct new vertical infrastructure through construction contracts, agreements with local government entities responsible for managing state parks and other public facilities, and agreements with the department of corrections to use offender labor where possible. Funds shall also be used to support site survey, design and construction contract management through consulting engineering and architectural firms and for direct survey, design and construction management costs incurred by department engineering and architectural staff for restore the outdoors projects. Funds shall not be used to support general department oversight of the restore the outdoors program, such as accounting, general administration or long-range planning.

571—61.15(461A,463C) Honey Creek Resort State Park. This chapter shall not apply to Honey Creek Resort State Park, with the exception that subrules 61.7(1) through 61.7(9) and 61.7(11) through 61.7(16) and rule 61.12(461A) shall apply to the operation and management of Honey Creek Resort State Park. Where permission is required to be obtained from the department, an authorized representative of the department's management company may provide such permission in accordance with policies established by the department.

These rules are intended to implement Iowa Code sections 422.43, 455A.4, 461A.3, 461A.3A, 461A.35, 461A.38, 461A.39, 461A.42, 461A.43, 461A.45 to 461A.51, 461A.57, and 723.4 and Iowa Code chapters 463C and 724.

[Filed 9/14/65]

[Filed 5/5/78, Notice 3/8/78—published 5/31/78, effective 7/6/78]

[Filed 7/13/82, Notice 4/28/82—published 8/4/82, effective 9/8/82]

[Filed 4/7/83, Notice 2/2/83—published 4/27/83, effective 6/1/83]

- [Filed 11/4/83, Notice 9/28/83—published 11/23/83, effective 12/28/83]
- [Filed 2/6/84, Notice 12/21/83—published 2/29/84, effective 4/5/84]
- [Filed 4/5/85, Notice 1/30/85⁰—published 4/24/85, effective 5/30/85]
- [Filed 5/8/85, Notice 1/30/85—published 6/5/85, effective 7/10/85]
- [Filed emergency 5/31/85—published 6/19/85, effective 7/1/85]
- [Filed emergency 6/11/86—published 7/2/86, effective 6/13/86]
- [Filed 10/17/86, Notice 7/2/86—published 11/5/86, effective 12/10/86]
- [Filed without Notice 12/12/86—published 12/31/86, effective 2/4/87]
- [Filed 3/20/87, Notice 1/28/87—published 4/8/87, effective 5/13/87]
- [Filed 10/16/87, Notice 8/26/87—published 11/4/87, effective 2/3/88]
- [Filed emergency 7/7/89—published 7/26/89, effective 7/7/89]
- [Filed 3/15/91, Notices 10/3/90, 12/26/90—published 4/3/91, effective 5/8/91]
- [Filed 6/7/91, Notice 4/3/91—published 6/26/91, effective 7/31/91]¹
- [Filed emergency 10/4/91 after Notice 8/7/91—published 10/30/91, effective 10/4/91]
- [Filed 3/13/92, Notice 12/25/91—published 4/1/92, effective 5/6/92]
- [Filed 5/8/92, Notice 4/1/92—published 5/27/92, effective 7/1/92]²
- [Filed emergency 8/7/92—published 9/2/92, effective 8/7/92]
- [Filed 12/4/92, Notice 9/30/92—published 12/23/92, effective 1/27/93]
- [Filed 8/13/93, Notice 6/23/93—published 9/1/93, effective 1/1/94]³
- [Filed 8/12/94, Notice 6/8/94—published 8/31/94, effective 10/5/94]
- [Filed 9/9/94, Notice 7/6/94—published 9/28/94, effective 11/2/94]
- [Filed emergency 10/27/94—published 11/23/94, effective 10/27/94]
- [Filed emergency 2/9/95—published 3/1/95, effective 2/10/95]
- [Filed 5/15/95, Notice 3/1/95—published 6/7/95, effective 7/12/95]
- [Filed 10/20/95, Notice 8/30/95—published 11/8/95, effective 12/13/95]
- [Filed 8/9/96, Notice 6/5/96—published 8/28/96, effective 10/2/96]
- [Filed 8/9/96, Notice 7/3/96—published 8/28/96, effective 10/2/96]
- [Filed without Notice 10/18/96—published 11/6/96, effective 1/1/97]
- [Filed 2/21/97, Notice 1/1/97—published 3/12/97, effective 4/16/97]
- [Filed 8/22/97, Notice 6/4/97—published 9/10/97, effective 10/15/97]
- [Filed 2/20/98, Notice 12/31/97—published 3/11/98, effective 4/15/98]
- [Filed emergency 5/29/98—published 6/17/98, effective 5/29/98]
- [Filed 8/21/98, Notice 6/17/98—published 9/9/98, effective 10/14/98]
- [Filed emergency 12/11/98 after Notice 11/4/98—published 12/30/98, effective 1/1/99]
- [Filed 8/20/99, Notice 6/30/99—published 9/8/99, effective 10/13/99]
- [Filed emergency 12/10/99 after Notice 11/3/99—published 12/29/99, effective 1/1/00]
- [Filed 11/13/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
- [Filed 8/17/01, Notice 5/30/01—published 9/5/01, effective 10/10/01]
- [Filed emergency 12/19/01 after Notice 10/31/01—published 1/9/02, effective 1/1/02]
- [Filed 10/11/02, Notice 9/4/02—published 10/30/02, effective 12/4/02]
- [Filed 2/14/03, Notice 1/8/03—published 3/5/03, effective 4/9/03]
- [Filed 8/15/03, Notice 7/9/03—published 9/3/03, effective 10/8/03]
- [Filed 11/19/03, Notice 10/1/03—published 12/10/03, effective 1/14/04]
- [Filed 5/20/04, Notice 3/31/04—published 6/9/04, effective 7/14/04]
- [Filed 11/17/04, Notice 9/29/04—published 12/8/04, effective 1/12/05]
- [Filed emergency 6/28/05—published 7/20/05, effective 6/29/05]
- [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
- [Filed without Notice 3/23/06—published 4/12/06, effective 5/17/06]
- [Filed 8/11/06, Notice 6/7/06—published 8/30/06, effective 10/4/06]
- [Filed 3/19/08, Notice 2/13/08—published 4/9/08, effective 5/14/08]
- [Filed ARC 7683B (Notice ARC 7499B, IAB 1/14/09), IAB 4/8/09, effective 5/13/09]
- [Filed ARC 7684B (Notice ARC 7539B, IAB 1/28/09), IAB 4/8/09, effective 5/13/09]

[Filed ARC 8821B (Notice ARC 8593B, IAB 3/10/10), IAB 6/2/10, effective 7/7/10]
[Filed ARC 9186B (Notice ARC 8819B, IAB 6/2/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9324B (Notice ARC 9118B, IAB 10/6/10), IAB 1/12/11, effective 2/16/11]
[Filed ARC 9541B (Notice ARC 9421B, IAB 3/9/11), IAB 6/1/11, effective 7/6/11]

⁰ Two or more ARCs

¹ Effective date of subrule 61.6(2) and rule 61.7(7/31/91) delayed 70 days by the Administrative Rules Review Committee at its meeting held 7/12/91.

² Amendments to 61.4(2) "f" and 61.3(5) "a" effective January 1, 1993.

³ Amendments to 61.4(2) "a" to "d" effective October 31, 1993.

CHAPTER 65
FIREWORKS DISPLAYS—
STATE PARKS AND RECREATION AREAS
Rescinded IAB 6/1/11, effective 7/6/11; see 571—Chapter 44

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

641—88.1(135) Purpose. The volunteer health care provider program (VHCPP) is established to defend and indemnify eligible individual volunteer health care providers and protected clinics providing free health care services as provided in Iowa Code section 135.24 and these rules.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.2(135) Definitions. For the purpose of these rules, the following definitions shall apply:

“Charitable organization” means a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code.

“Defend” means that the office of the attorney general shall provide the individual volunteer health care provider and protected clinic with legal representation at no cost to the individual volunteer health care provider or protected clinic.

“Department” means the Iowa department of public health.

“Field dental clinic” means a dental clinic temporarily or periodically erected at a location where mobile dental equipment, instruments, or supplies, as necessary, are utilized to provide dental services.

“Free clinic” means a facility, other than a hospital or health care provider’s office, which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and which has as its sole purpose the provision of health care services without charge to individuals who are otherwise unable to pay for the services.

“Health care facility” means a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with mental retardation.

“Health care provider” means an emergency medical care provider certified pursuant to Iowa Code chapter 147A; a physician licensed pursuant to Iowa Code chapter 148; a physical therapist licensed pursuant to Iowa Code chapter 148A; an occupational therapist licensed pursuant to Iowa Code chapter 148B; a physician assistant licensed pursuant to Iowa Code chapter 148C and practicing under the supervision of a physician; a podiatrist licensed pursuant to Iowa Code chapter 149; a chiropractor licensed pursuant to Iowa Code chapter 151; a respiratory therapist licensed pursuant to Iowa Code chapter 152B; an advanced registered nurse practitioner, a licensed practical nurse or a registered nurse licensed pursuant to Iowa Code chapter 152 or 152E; a dentist, dental assistant, or dental hygienist licensed or registered pursuant to Iowa Code chapter 153; an optometrist licensed pursuant to Iowa Code chapter 154; a psychologist licensed pursuant to Iowa Code chapter 154B; a bachelor social worker, a master social worker, or an independent social worker licensed pursuant to Iowa Code chapter 154C; a marital and family therapist or mental health counselor licensed pursuant to Iowa Code chapter 154D; a speech pathologist or audiologist licensed pursuant to Iowa Code chapter 154F; or a pharmacist licensed pursuant to Iowa Code chapter 155A.

“Health care services” means services received from a health care provider at a protected clinic or sponsor entity, as provided in Iowa Code section 135.24 and these rules, and approved in a protection agreement or sponsor entity agreement. The agreement covers “health care services” that are volunteer, uncompensated services. For those services to qualify as volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, protected clinic, or sponsor entity must receive no compensation for any services provided under the agreement and must not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided.

“Indemnify” means that the state of Iowa shall pay all sums that the individual volunteer health care provider or protected clinic holding a protection agreement with the VHCPP is legally obligated to pay as damages because of any claim made against the individual volunteer health care provider or protected clinic which arises out of the provision of free health care services rendered or which should have been rendered by the individual volunteer health care provider or protected clinic.

“Individual volunteer health care provider” means any one of the following health care providers who has a fully executed protection agreement with the VHCPP: an emergency medical care provider

certified pursuant to Iowa Code chapter 147A; a physician licensed pursuant to Iowa Code chapter 148; a physical therapist licensed pursuant to Iowa Code chapter 148A; an occupational therapist licensed pursuant to Iowa Code chapter 148B; a physician assistant licensed pursuant to Iowa Code chapter 148C and practicing under the supervision of a physician; a podiatrist licensed pursuant to Iowa Code chapter 149; a chiropractor licensed pursuant to Iowa Code chapter 151; a respiratory therapist licensed pursuant to Iowa Code chapter 152B; an advanced registered nurse practitioner, a licensed practical nurse or a registered nurse licensed pursuant to Iowa Code chapter 152 or 152E; a dentist, dental assistant, or dental hygienist licensed or registered pursuant to Iowa Code chapter 153; an optometrist licensed pursuant to Iowa Code chapter 154; a psychologist licensed pursuant to Iowa Code chapter 154B; a bachelor social worker, a master social worker, or an independent social worker licensed pursuant to Iowa Code chapter 154C; a marital and family therapist or mental health counselor licensed pursuant to Iowa Code chapter 154D; a speech pathologist or audiologist licensed pursuant to Iowa Code chapter 154F; or a pharmacist licensed pursuant to Iowa Code chapter 155A.

“Major surgical procedure” means a surgical procedure not ordinarily performed in a private provider’s office, free clinic, or specialty health care provider office and includes the surgery performed in a hospital as defined in Iowa Code section 135B.1(3) or an outpatient surgical facility.

“Minor surgical procedure” means a surgical procedure ordinarily performed in a private provider’s office, free clinic, or specialty health care provider office.

“Outpatient surgical facility” means a facility defined in Iowa Code section 135.61(21).

“Protected clinic” means field dental clinic, free clinic, or specialty health care provider office providing free care to the uninsured and underinsured. Each protected clinic has a signed protection agreement, which provides for defense and indemnification of the protected clinic. The protection agreement shall allow the protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state.

“Protection agreement” means a signed contract providing for defense and indemnification between an individual volunteer health care provider or protected clinic and the volunteer health care provider program (VHCPP). This agreement shall allow the individual health care provider or protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state. The agreement covers “health care services” that are volunteer, uncompensated services. For those services to qualify as volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, and protected clinic must receive no compensation for any services provided under the agreement and must not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided by the individual volunteer health care provider covered by the agreement.

“Specialty care referral network” means the referral network established through the Iowa Collaborative Safety Net Provider Network.

“Specialty health care provider office” means the private office or clinic of an individual specialty health care provider or a group of specialty health care providers as referred by the Iowa Collaborative Safety Net Provider Network established in Iowa Code section 135.153 but does not include a field dental clinic, a free clinic, or a hospital.

“Sponsor entity” or *“sponsor entity clinic”* means a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, outpatient surgical facility, or field dental clinic. Each sponsor entity has a fully executed sponsor entity agreement. The sponsor entity agreement shall allow an individual volunteer health care provider to deliver health care services to uninsured and underinsured persons as an agent of the state.

“Sponsor entity agreement” means a signed contract between the VHCPP and a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, outpatient surgical facility, or field dental clinic allowing an individual volunteer health care provider to deliver free health care services through the VHCPP at the sponsor entity location.

“Underinsured” means that a person does not have adequate insurance, which is determined on cost-exposure to family income with at least one of three indicators: (1) out-of-pocket medical expenses equal to or greater than 10 percent of income; (2) out-of-pocket medical expenses equal to or greater

than 5 percent of income if income is less than 200 percent of the federal poverty level; and (3) health plan deductibles equal to or greater than 5 percent of income.

“*Volunteer health care provider program*” or “*VHCPP*” means the volunteer health care provider program of the department.

[**ARC 8791B**, IAB 6/2/10, effective 7/7/10; **ARC 9535B**, IAB 6/1/11, effective 5/11/11; **ARC 9536B**, IAB 6/1/11, effective 5/11/11]

641—88.3(135) Eligibility for the volunteer health care provider program.

88.3(1) *Individual volunteer health care provider eligibility.* To be eligible for protection as an employee of the state under Iowa Code chapter 669 for a claim arising from covered health care services, an individual volunteer health care provider shall satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

a. The individual volunteer health care provider shall hold an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A. The individual volunteer health care provider shall provide a sworn statement attesting that the license, registration, or certification to practice is free of restrictions. The statement shall describe any disciplinary action that has ever been taken against the individual volunteer health care provider by any professional licensing, registering, or certifying authority or health care facility, including any voluntary surrender of license, registration, or certification or other agreement involving the individual volunteer health care provider’s license, registration, or certification to practice or any restrictions on practice, suspension of privileges, or other sanctions. The statement shall also describe any malpractice suits that have been filed against the individual volunteer health care provider. The statement provided by a pharmacist shall also describe any disciplinary action that has ever been taken against any pharmacy in which the pharmacist has ever been owner, partner, or officer.

(1) Every physician and dentist shall authorize the release of information allowing certified statements to be sent to the board of medicine or dental board from the National Practitioner Data Bank, the Federation of State Medical Boards Disciplinary Data Bank, or State Dental Boards Disciplinary Data Bank, as appropriate, setting forth any malpractice judgment or award or disciplinary action involving the physician or dentist.

(2) Every physical therapist, occupational therapist, physician assistant, podiatrist, chiropractor, respiratory therapist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, optometrist, psychologist, bachelor social worker, master social worker, independent social worker, marital and family therapist, mental health counselor, speech pathologist, and audiologist shall request certified statements directly from the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank setting forth any malpractice judgment or award or disciplinary action involving the requester, shall pay the cost for such certified statements and shall submit such certified statements as part of the VHCPP application. Every chiropractor shall also authorize the release of information allowing certified statements to be sent to the board of chiropractic from the Chiropractic Information Network-Board Action Databank (CIN-BAD) setting forth any malpractice judgment or award or disciplinary action involving the chiropractor.

(3) Every pharmacist shall authorize the release of information allowing certified statements to be sent to the board of pharmacy from the National Association of Boards of Pharmacy setting forth any disciplinary action involving the pharmacist or any pharmacy in which the pharmacist has ever been owner, partner, or officer, and the pharmacist shall pay the cost for such certified statements. Every pharmacist shall also authorize the release of information from the pharmacist’s malpractice insurance carrier to be sent to the board of pharmacy, and the pharmacist shall pay the cost for such release. Information released from the pharmacist’s malpractice insurance carrier shall include the history and details of all claims that have been filed on behalf of the pharmacist or any pharmacy in which the pharmacist has ever been owner, partner, or officer, or confirmation that there have been no claims.

(4) Every emergency medical care provider shall authorize the release of information allowing information to be sent from the bureau of emergency medical services to the VHCPP setting forth any malpractice judgment or award or disciplinary action involving the requester and shall authorize the

release of information allowing such information to be shared with the bureau of emergency medical services by licensing entities within and outside Iowa.

b. Application. The applicant shall submit the following information on forms provided by the VHCPP:

- (1) The patients to be served;
- (2) The health care services to be provided;
- (3) The site where health care services are to be provided;
- (4) The days and maximum number of hours when the free health care services will be provided each week at each site;
- (5) The services that will be provided to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

c. Agreement. The individual volunteer health care provider shall have a signed and current protection agreement with the VHCPP which identifies the covered health care services within the respective scope of practice and conditions of defense and indemnification as provided in rules 641—88.5(135) and 641—88.6(135). The protection agreement shall:

- (1) Provide that the individual volunteer health care provider shall perform only those health care services identified and approved by the VHCPP;
- (2) Identify the health care services to be provided by the sponsor entity or protected clinic which has been approved by the VHCPP through an application process;
- (3) Identify by category the patient groups to be served;
- (4) Identify the sites at which the free health care services will be provided;
- (5) Identify the maximum amount of time the free health care services will be provided by the individual volunteer health care provider at the identified sites each week;
- (6) Provide that the individual volunteer health care provider shall maintain proper records of the health care services;
- (7) Provide that the individual volunteer health care provider shall make no representations concerning eligibility for the VHCPP or eligibility of services for indemnification by the state except as authorized by the department;
- (8) Provide that the individual volunteer health care provider shall cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;
- (9) Provide that the individual volunteer health care provider shall accept financial responsibility for personal expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the individual volunteer health care provider for the individual volunteer health care provider's expenses or time needed for the defense of the claim or suit;
- (10) Provide that the individual volunteer health care provider shall receive no direct monetary compensation of any kind for services provided in the VHCPP;
- (11) Provide that the individual volunteer health care provider shall comply with the protection agreement with the VHCPP concerning approved health care services.

88.3(2) Protected clinic eligibility. To be eligible for protection as a state agency under Iowa Code chapter 669 for a claim arising from the provision of covered health care services at a protected clinic, the protected clinic shall satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

- a.* The protected clinic shall comply with subrules 88.4(1) through 88.4(5).
- b.* The protected clinic shall have provided to the department a list of all health care providers who provide health care services at the protected clinic.
- c.* The protected clinic shall have submitted proof to the department that each health care provider providing health care services at the protected clinic either:
 - (1) Holds a current protection agreement with the VHCPP, or

(2) Holds current professional liability insurance coverage and an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A.

d. The protected clinic shall submit a list of the clinic board of directors and contact information for the board of directors, if applicable.

e. If the protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the protected clinic shall provide proof of Section 501(c)(3) status to the VHCPP.

f. A protected clinic may allow health care profession students to volunteer at the protected clinic provided that the following conditions are satisfied:

(1) The college, university, or other health care profession educational institution provides professional liability insurance which covers the students; and

(2) The protected clinic or the health care profession institution provides general liability and professional liability insurance which covers the students; and

(3) The students provide only those services or activities as are authorized by the education agreement, and such services and activities are provided under the on-site supervision of a health care provider.

88.3(3) Sponsor entity or sponsor entity clinic. As a condition of sponsoring individual volunteer health care providers in the VHCPP, a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, outpatient surgical facility, or field dental clinic shall comply with subrules 88.4(1) through 88.4(5).

[ARC 8791B, IAB 6/2/10, effective 7/7/10; ARC 9535B, IAB 6/1/11, effective 5/11/11; ARC 9536B, IAB 6/1/11, effective 5/11/11]

641—88.4(135) Sponsor entity and protected clinic.

88.4(1) Licensure. The sponsor entity or protected clinic shall be licensed to the extent required by law for the facility in question.

88.4(2) If the sponsor entity or protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the sponsor entity or protected clinic shall provide proof of Section 501(c)(3) status to the VHCPP.

88.4(3) Application. The sponsor entity or protected clinic shall submit the following information on forms provided by the VHCPP:

- a.* By category, the patient groups to be served;
- b.* The health care services to be provided;
- c.* The site where free health care services are to be provided;
- d.* The days and times when health care services are to be provided at each site;
- e.* The services that will be provided to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

88.4(4) Agreement. A signed and current sponsor entity agreement or protected clinic agreement shall exist with the VHCPP which shall:

- a.* Provide that the individual volunteer health care provider or health care provider within a sponsor entity or protected clinic shall perform only those health care services identified and approved by the VHCPP;
- b.* Identify by category the patient groups to be served;
- c.* Identify the sites at which the free health care services will be provided;
- d.* Identify the days and times when health care services are to be provided at each site;
- e.* Provide that the sponsor entity or protected clinic shall maintain proper records of health care services for a period of seven years from the date of service or, in the case of a minor, for a period of one year after the minor has reached the age of majority; and

f. Provide that the sponsor entity agrees that only the individual volunteer health care provider or protected clinic is afforded protection under Iowa Code section 135.24 and that the state assumes no obligation to the sponsor entity, its employees, officers, or agents. The sponsor entity or protected clinic

shall submit a statement, which shall be submitted on forms provided by the VHCPP, attesting that the sponsor entity or protected clinic and its staff, employees and volunteers agree to:

(1) Cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;

(2) Accept financial responsibility for the sponsor entity's or protected clinic's expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the sponsor entity or protected clinic for expenses or time needed for the defense of the claim or suit;

(3) Receive no direct monetary compensation of any kind for health care services provided in the sponsor entity or protected clinic;

(4) Comply with the sponsor entity agreement or protected clinic agreement with the VHCPP concerning approved health care services.

88.4(5) General liability insurance. The sponsor entity or protected clinic shall submit proof of general liability insurance for the clinic site.

[ARC 8791B, IAB 6/2/10, effective 7/7/10; ARC 9536B, IAB 6/1/11, effective 5/11/11]

641—88.5(135) Covered health care services. An individual volunteer health care provider holding a current protection agreement with the VHCPP shall be afforded the protection of an employee of the state under Iowa Code chapter 669, and a protected clinic holding a current protection agreement with the VHCPP shall be afforded protection as an agency of the state under Iowa Code chapter 669, only for claims for injury alleged to have been proximately caused by an individual volunteer health care provider's provision of covered health care services or solely on the basis of the individual volunteer health care provider's participation in the sponsor entity or protected clinic.

88.5(1) Covered health care services are only those that are:

- a. Identified in the protection agreement with the VHCPP;
- b. In compliance with these rules;
- c. Provided by or under the direct supervision of the individual volunteer health care provider;
- d. Health care services of:

(1) Advanced registered nurse practitioners for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Certified registered nurse anesthetists may provide anesthesia services for major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an outpatient surgical facility;

2. The hospital or outpatient surgical facility at which the surgery is performed has executed a sponsor entity agreement;

3. The physician performing the surgery provides or assures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and

4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers which has registered with the department as a specialty health care provider office.

(2) Audiologists for: testing, measurement and evaluation related to hearing and hearing disorders and associated communication disorders for the purpose of nonmedically identifying, preventing, modifying or remediating such disorders and conditions including the determination and use of appropriate amplification; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

(3) Bachelor social workers for: psychosocial assessment and intervention through direct contact with clients; referral to other qualified resources for assistance; performance of social histories; problem identification; establishment of goals and monitoring of progress; interviewing techniques; counseling; social work administration; supervision; evaluation; interdisciplinary consultation and collaboration.

(4) Chiropractors for: examinations; diagnosis and treatment; health education; and health maintenance.

(5) Dental assistants for: intraoral services; extraoral services; infection control; radiography; and removal of plaque or stain by toothbrush, floss, or rubber cup coronal polish.

(6) Dental hygienists for: assessments and screenings; health education; health maintenance; and preventive services (cleaning, X-rays, sealants, fluoride treatments, fluoride varnish).

(7) Dentists for: dental examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; and minor surgical procedures.

(8) Emergency medical care providers for: airway/ventilation/oxygenation; assisted medications - patient's; cardiovascular/circulation; immobilization; IV initiation/maintenance/fluids; and medication administration - routes.

(9) Independent social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(10) Licensed practical nurses for: supportive or restorative care.

(11) Marital and family therapists for: marital and family therapy; and application of counseling techniques in the assessment and resolution of emotional conditions.

(12) Master social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(13) Mental health counselors for: mental health counseling; and counseling services involving assessment, referral and consultation.

(14) Occupational therapists for: evaluation and treatment of problems interfering with functional performance in persons impaired by physical illness or injury, emotional disorder, congenital or developmental disability or the aging process.

(15) Optometrists for: examinations; diagnosis and treatment of the human eye and adnexa; health education; and health maintenance.

(16) Pharmacists for: drug dispensing; patient counseling; health screenings and education; and immunizations.

(17) Physical therapists for: interpretation of performance, tests, and measurements; evaluation and treatment of human capabilities and impairments; use of physical agents, therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment; establishment and modification of physical therapy program; treatment planning; and patient instruction/education.

(18) Physicians and physician assistants for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Physicians may perform major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an outpatient surgical facility;

2. The hospital or outpatient surgical facility at which the surgery is performed has executed a sponsor entity agreement;

3. The physician provides or assures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and

4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers which has registered with the department as a specialty health care provider office.

(19) Podiatrists for: examinations; diagnosis and treatment; health education; health maintenance; and minor surgical procedures.

(20) Psychologists for: counseling and the use of psychological remedial measures with persons with adjustment or emotional problems.

(21) Registered nurses for: well-child examinations; annual adult examinations; treatment of acute and chronic conditions; health education; health maintenance; and immunizations.

(22) Respiratory therapists for: diagnostic and therapeutic use of administration of medical gases, aerosols, and humidification, not including general anesthesia; pharmacologic agents relating to respiratory care procedures; bronchopulmonary hygiene; specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment, and research of cardiopulmonary abnormalities; and pulmonary function testing.

(23) Speech pathologists for: testing, measurement and evaluation related to the development and disorders of speech, fluency, voice or language for the purpose of nonmedically preventing, ameliorating, modifying or remediating such disorders and conditions; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

88.5(2) Experimental procedures or procedures and treatments which lack sufficient evidence of clinical effectiveness are excluded from the VHCPP.

88.5(3) Patient referral to a specialty health care provider office shall be made solely by the specialty care referral network.

[ARC 8791B, IAB 6/2/10, effective 7/7/10; ARC 9535B, IAB 6/1/11, effective 5/11/11]

641—88.6(135) Defense and indemnification. The state shall defend and indemnify an individual volunteer health care provider or a protected clinic for a claim arising from the VHCPP only to the extent provided by Iowa Code chapter 669 and Iowa Code section 135.24. Persons or entities other than the participating individual volunteer health care provider or protected clinic are not considered state employees or state agencies under Iowa Code chapter 669. Defense and indemnification of the individual volunteer health care provider or a protected clinic under Iowa Code chapter 669 and Iowa Code section 135.24 shall occur only if all of the following requirements are met:

88.6(1) The claim involves medical injury alleged to have been proximately caused by health care services which were identified and approved in the protection or sponsor agreement with the VHCPP and then only to the extent the health care services were provided by or under the direct supervision of the individual volunteer health care provider, including claims based on negligent delegation of health care, or the individual volunteer health care provider is named as a defendant solely because of the individual volunteer health care provider's participation in the protected clinic or sponsor entity clinic.

88.6(2) The claim arises from covered health care services that were performed at a site identified and approved in the protection agreement with the VHCPP.

88.6(3) The claim arises from covered health care services provided through a protected clinic or sponsor entity clinic identified and approved in the individual volunteer health care provider's protection agreement with the VHCPP and which meets the requirements of rule 641—88.3(135).

88.6(4) The individual volunteer health care provider, health care provider, protected clinic, or sponsor entity clinic that provided the health care services receives no direct monetary compensation of any kind and no promise to pay compensation for the health care services which allegedly resulted in medical injury.

88.6(5) The health care services are provided to a patient who is a member of a patient group identified in the protection agreement with the VHCPP.

88.6(6) The individual volunteer health care provider, protected clinic, or sponsor entity clinic is eligible and registered as provided in rule 641—88.3(135) or the care is provided by a health care provider who holds current professional liability insurance coverage and an active unrestricted license to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A and has been approved by the VHCPP.

[ARC 8791B, IAB 6/2/10, effective 7/7/10; ARC 9535B, IAB 6/1/11, effective 5/11/11; ARC 9536B, IAB 6/1/11, effective 5/11/11]

641—88.7(135) Term of agreement.

88.7(1) Individual volunteer health care provider. The protection agreement with the VHCPP shall expire two years from the date of execution. Individual volunteer health care providers may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement.

88.7(2) Protected clinic. The protection agreement with the VHCPP shall expire two years from the date of execution. The protected clinic may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement.

88.7(3) Sponsor entity. The sponsor entity agreement with the VHCPP shall expire two years from the date of execution. Sponsor entities may apply for renewal by filing an application at least 30 days prior to expiration of the sponsor entity agreement.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.8(135) Reporting requirements and duties.

88.8(1) Upon obtaining knowledge or becoming aware of any injury allegedly arising out of the negligent rendering of, or the negligent failure to render, covered health care services under the VHCPP, a participating individual volunteer health care provider, protected clinic, or sponsor entity shall provide to the VHCPP, as soon as practicable, written notice containing, to the extent obtainable, the circumstance of the alleged injury, the names and addresses of the injured, and any other relevant information.

88.8(2) Upon obtaining knowledge or becoming aware of an injury as defined in subrule 88.8(1), the participating protected clinic or sponsor entity shall promptly take all reasonable steps to prevent further or other injury from arising out of the same or similar incidents, situations or conditions.

88.8(3) A participating individual volunteer health care provider, protected clinic, or sponsor entity shall immediately notify the Iowa Department of Justice, Special Litigation Division, Hoover State Office Building, Des Moines, Iowa 50319, of service or receipt of an original notice, petition, suit or claim seeking damages from the individual volunteer health care provider, protected clinic or sponsor entity related to participation in the VHCPP.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.9(135) Revocation of agreement. The VHCPP may deny, suspend, revoke, or condition the agreement of an individual volunteer health care provider, protected clinic or sponsor entity for cause, including but not limited to:

1. Failure to comply with the protection agreement or sponsor entity agreement with the VHCPP.
2. Violation of state law governing the respective scope of practice or other law governing the health care services provided under the VHCPP.
3. Making false, misleading, or fraudulent statements in connection with the VHCPP, including determination of eligibility of the individual volunteer health care provider, protected clinic, or sponsor entity or handling of a claim against the individual volunteer health care provider, protected clinic, sponsor entity or the state.
4. Evidence of substance abuse or intoxication affecting the provision of health care services under the VHCPP.
5. Reasonable grounds to believe that the individual volunteer health care provider or health care provider may have provided incompetent or inadequate care to a patient under the VHCPP or is likely to do so.
6. Reasonable grounds to believe that the individual volunteer health care provider's, protected clinic's, or sponsor entity's participation in the VHCPP may expose the state to undue risk.
7. Failure to immediately notify the VHCPP of any disciplinary action brought against the individual volunteer health care provider by the applicable state licensing board.

[ARC 8791B, IAB 6/2/10, effective 7/7/10; ARC 9536B, IAB 6/1/11, effective 5/11/11]

641—88.10(135) Procedure for revocation of agreement. A proceeding for revocation of an individual volunteer health care provider's protection agreement or a protected clinic's protection agreement or a sponsor entity's agreement for participation shall be conducted as a contested case proceeding pursuant to Iowa Code chapter 17A and 641—Chapter 173. Iowa Code section 17A.18 does not preclude emergency summary suspension of a protection agreement or a sponsor entity agreement. The VHCPP shall immediately notify the appropriate licensing board and the appropriate protected

clinic or sponsor entity of revocation of an individual volunteer health care provider's protection agreement.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.11(135) Effect of suspension or revocation. If the VHCPP suspends or revokes an individual volunteer health care provider's protection agreement, sponsor entity agreement, or protected clinic's protection agreement, the action shall suspend or revoke future protection but shall not negate defense and indemnification coverage for covered acts or omissions which occurred during the effective dates of the protection agreement.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.12(135) Protection denied.

88.12(1) Protection denied—appeal procedure. An applicant who has been denied protection by the VHCPP may appeal the denial and request a hearing on the issues related to the denial by serving a notice of the appeal and request for hearing to the Director, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075, in writing, not more than 30 days following the date of the mailing of the notification of protection denial to the applicant or not more than 30 days following the date upon which the applicant was served notice if notification was made in the manner of service of an original notice. The request for hearing shall specifically delineate the facts to be contested and determined at the hearing.

88.12(2) Protection denied—hearing. If an applicant who has been denied protection by the VHCPP appeals the protection denial and requests a hearing pursuant to subrule 88.12(1), the hearing and subsequent procedures shall be conducted pursuant to Iowa Code chapter 17A and 641—Chapter 173.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.13(135) Board notice of disciplinary action. The applicable state licensing board shall notify the VHCPP of the initiation of a contested case against a protected individual volunteer health care provider or the imposition of disciplinary action, including providing copies of any contested case decision or settlement agreement with the protected individual volunteer health care provider upon request of the VHCPP.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.14(135) Effect of eligibility protection. A fully executed protection agreement of an individual volunteer health care provider or protected clinic as eligible for participation in the VHCPP by the applicable state licensing board and the department is solely a determination that the state will defend and indemnify the individual volunteer health care provider or the protected clinic to the extent provided by Iowa Code section 135.24 and these rules. The protection is not an approval or indication of ability or competence and may not be represented as such. The protected clinic or sponsor entity through which the individual volunteer health care provider provides free health care services shall retain responsibility for determining that health care personnel are competent and capable of adequately performing the health care services to be provided.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

641—88.15(135) Reporting by a protected clinic or sponsor entity. A reporting form will be provided by the VHCPP to the participating protected clinic or sponsor entity at the time the protected clinic or sponsor entity agreement is approved by the VHCPP. Within 60 days following each calendar quarter, the protected clinic or sponsor entity shall provide a report to the VHCPP. At a minimum, the report shall include the number of clinic patients receiving free health care services and patient demographics by age, ethnicity, and insurance status.

[ARC 8791B, IAB 6/2/10, effective 7/7/10]

These rules are intended to implement Iowa Code section 135.24.

[Filed 3/25/94, Notice 2/2/94—published 4/13/94, effective 5/18/94]

[Filed 1/11/96, Notice 11/8/95—published 1/31/96, effective 3/6/96]

[Filed emergency 7/10/98—published 7/29/98, effective 7/10/98]

[Filed 9/18/98, Notice 7/29/98—published 10/7/98, effective 11/11/98]

[Filed 5/22/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]

[Filed 1/16/04, Notice 11/26/03—published 2/4/04, effective 3/10/04]

[Filed 7/16/04, Notice 5/26/04—published 8/4/04, effective 9/8/04]

[Filed 1/12/06, Notice 12/7/05—published 2/1/06, effective 3/8/06]

[Filed ARC 8791B (Notice ARC 8627B, IAB 3/24/10), IAB 6/2/10, effective 7/7/10]

[Filed Emergency After Notice ARC 9535B (Notice ARC 9245B, IAB 12/1/10), IAB 6/1/11, effective 5/11/11]

[Filed Emergency ARC 9536B, IAB 6/1/11, effective 5/11/11]

CHAPTER 126
 STATE MEDICAL EXAMINER
 [Prior to 4/20/88, see Medical Examiner, State[566] Ch 1]
 [Prior to 6/30/99, see Public Safety Department[661] Ch 21]

641—126.1(144,331,691) Definitions.

“Autopsy” means the external and internal postmortem examination of a deceased person.

“County of appointment” means the county which requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

641—126.2(691) Medical examiner coverage. Rescinded IAB 12/12/01, effective 1/16/02.

641—126.3(691) Fees for autopsies and related services and reimbursement for related expenses. Autopsies performed by the state medical examiner are provided on a fee-for-service basis. Costs of autopsies and related services and expenses are the responsibility of the county of appointment. The county of residence of the deceased shall reimburse the county of appointment.

126.3(1) Fee schedule. The following fees shall apply to autopsies conducted by the state medical examiner:

Autopsy	\$1400
Copies of reports	\$20

EXCEPTIONS: A copy of the autopsy report is automatically sent to the county medical examiner and to the county attorney without fee. A single copy of an autopsy report may be provided to the immediate next of kin of the deceased without fee. Copies of autopsy reports may be provided to public officials and physicians of record for official purposes without fee.

State, deputy, or associate medical examiner(s) time for all court cases	\$450 per hour with a one-hour minimum
---	--

This fee is for time spent reviewing case materials, preparing for deposition or court, testifying in deposition or court, and travel time.

A cremation permit fee of \$75 will be assessed for each permit investigated and authorized by the state medical examiner’s office.

126.3(2) Expense reimbursement. Other laboratory services associated with an autopsy, which shall include, but not be limited to, photography, toxicology, radiology, microbiology, and morgue fees, shall be billed by the department to the county of appointment. Moneys collected pursuant to this subrule shall be paid by the department to the laboratory or other entity providing the service.

126.3(3) State medical examiner acting as county medical examiner. When the state medical examiner acts in the capacity of county medical examiner, the state medical examiner shall receive from the county of appointment a fee of \$100 per hour, with a one-hour minimum, for each report prepared plus the state medical examiner’s actual expenses. Counties may not depend on the state medical examiner for full-time coverage.

[ARC 9533B, IAB 6/1/11, effective 7/6/11]

641—126.4(691) Fees for tissue recovery. When the tissue recovery room located within the office of the state medical examiner is utilized by an authorized tissue recovery agency, a fee of \$400 per case shall be assessed. The tissue recovery agency is responsible for this fee, payable to the office of the state medical examiner.

These rules are intended to implement Iowa Code section 691.6.

[Filed 11/1/84, Notice 6/6/84—published 11/21/84, effective 12/26/84]

[Filed 4/1/88, Notice 9/23/87—published 4/20/88, effective 5/25/88]

[Filed emergency 12/23/88 after Notice of 11/2/88—published 1/11/89, effective 12/23/88]

[Filed emergency 8/29/96—published 9/25/96, effective 9/1/96]

[Filed emergency 6/9/99—published 6/30/99, effective 6/9/99]

[Filed 11/19/01, Notice 10/3/01—published 12/12/01, effective 1/16/02]

[Filed 1/16/03, Notice 11/27/02—published 2/5/03, effective 3/12/03]

[Filed 1/10/07, Notice 11/22/06—published 1/31/07, effective 3/7/07]

[Filed ARC 9533B (Notice ARC 9435B, IAB 3/23/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE ABUSE AND PROBLEM GAMBLING
TREATMENT PROGRAMS

[Prior to 7/27/88, see Substance Abuse, Iowa Department of[805] Ch 3]

[Prior to 3/29/06, see 643—Ch 3]

641—155.1(125,135) Definitions. Unless otherwise indicated, the following definitions shall apply to the specific terms used in these rules:

“Accreditation body” means a national or not-for-profit body or organization recognized by the committee as meeting the criteria of the committee for deemed status.

“Acute intoxication or withdrawal potential” is a category to be considered in the ASAM-PPC-2R criteria. This category evaluates client/patient’s current status of intoxication and potential for withdrawal complications. Historical information about client/patient’s withdrawal patterns may also be considered.

“Administration” means the direct application of a prescription drug, whether by injection, inhalation, ingestion, or any other means, to the body of a client/patient or research subject by one of the following:

1. A practitioner or the practitioner’s authorized agent.
2. The client/patient or research subject at the direction of a practitioner.

“Admission” means the point in an individual’s relationship with the program at which the screening process has been completed and the individual is entitled to receive treatment services.

“Admission criteria” means specific ASAM-PPC-2R criteria to be considered in determining appropriate client/patient placement and resultant referral to a level of care (substance abuse treatment only). Criteria vary in intensity and are organized into categories to be used by treatment programs for assessment, to determine appropriate level of care, and for treatment planning.

“Affiliation agreement” means a written agreement between the governing authority of the program and another organization under the terms of which specified services, space or personnel are provided to one organization by the other, but without exchange of moneys.

“Applicant” means any treatment program which has applied for a license or renewal thereof.

“Application” means the process through which a treatment program applies for a license or renewal as outlined in the application procedures.

“ASAM-PPC-2R” means the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised.

“Assessment” means the ongoing process of identifying a diagnosis, ruling out other diagnoses, and determining the level of care needed by the client/patient.

“Biomedical conditions and complications” means one category to be considered in the ASAM-PPC-2R criteria. This category evaluates client/patient’s current physical condition. Historical information on client/patient’s medical/physical functioning may also be considered. This category includes biological and physical aspects of the medical assessment and treatment of a client/patient. Physical problems may be the direct result of a substance use disorder, or be independent of and interactive with such a disorder, thus affecting the total treatment plan and prognosis.

“Board” means the state board of health created pursuant to Iowa Code chapter 136.

“Case management” means the process of using predefined criteria to evaluate the necessity and appropriateness of client/patient care.

“Chemical dependency” means alcohol or drug dependence or psychoactive substance use disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), criteria or by other standardized and widely accepted criteria.

“Chemical dependency rehabilitation services” means those individual or group services that are directly related to chemical dependency or the individual treatment plan. These services include individual, group and family counseling, educational services, self-help groups and structured recreational activities. They do not include active employment or education courses beyond the secondary level.

“Chemical substance” means alcohol, wine, spirits and beer as defined in Iowa Code chapter 123 and controlled substances as defined in Iowa Code section 124.101.

“Client/patient” means an individual who is a substance abuser or a problem gambler or is chemically dependent, has been assessed as appropriate for services, and for whom screening procedures have been completed.

“Clinical oversight” means oversight provided by an individual who, by virtue of education, training and experience, is capable of assessing the psychosocial history of a client/patient to determine the most appropriate treatment plan. The person providing oversight shall be designated by the treatment program.

“Clinically managed high-intensity residential services (Level III.5)” means high-intensity residential services designed to address significant problems with living skills. The prime example of Level III.5 care is the therapeutic community, which provides a highly structured recovery environment in combination with moderate- to high-intensity professional clinical services to support and promote recovery. Client/patients must participate in at least 50 hours of structured chemical dependency rehabilitation services per week.

“Clinically managed low-intensity residential services (halfway house) (Level III.1)” means low-intensity professional addiction treatment services offered at least five hours per week. Treatment is directed toward applying recovery skills, preventing relapse, promoting personal responsibility and reintegrating the resident into the worlds of work, education and family life. The services may include individual, group and family therapy. Mutual/self-help meetings are available on site.

“Clinically managed medium-intensity residential services (Level III.3)” are frequently referred to as extended or long-term care. Level III.3 programs provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery. Client/patients must participate in at least 30 hours of structured chemical dependency rehabilitation services per week.

“Clinically managed services” means clinically managed services in which treatment is directed by addiction specialists rather than by medical professionals. They serve residents whose problems in the area of emotional/behavioral concerns, treatment acceptance, relapse potential, or recovery environment are the primary focus of treatment and problems in the areas of intoxication/withdrawal (Dimension 1) and biomedical concerns (Dimension 2), if any, are minimal.

“Committee” means the substance abuse and gambling treatment program committee appointed by the state board of health pursuant to Iowa Code section 136.3(13). The committee shall consist of three board members who are recommended by the board chairperson and approved by the board, including two members who have direct experience with substance abuse treatment or prevention and one member who represents the general public. The committee chairperson shall be one of the members who has substance abuse treatment or prevention experience as recommended by the board chairperson and approved by the board.

“Concerned family member” or *“concerned person”* means an individual who is seeking treatment services due to problems arising from the person’s involvement or association with a substance abuser, chemically dependent individual, problem gambler or client/patient and who is negatively affected by the behavior of the substance abuser, chemically dependent individual, problem gambler or client/patient.

“Continuing care” means a Level I service of the ASAM-PPC-2R criteria, which provides a specific period of structured therapeutic involvement designed to enhance, facilitate and promote transition from primary care to ongoing recovery. There shall not be any required frequency of review for continuing care or frequency of review of treatment plan by client/patient and counselor.

“Continuing service and discharge criteria” means, in accordance with ASAM-PPC-2R, during the process of client/patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care and the resolution of those problems and priorities determines when a client/patient can be treated at a different level of care or discharged from treatment. New problems may require services that can be provided effectively at the same level of care or may require a more intensive or less intensive level of care.

“Continuum of care” means a structure of interlinked treatment modalities and services designed so that a client/patient’s changing needs will be met as the client/patient moves through the treatment and recovery process.

“Contract” means a formal legal document adopted by the governing authority of the program and any other organization, agency, or individual that specifies services, personnel or space to be provided to the program as well as the moneys to be expended in the exchange.

“Counselor” means an individual who, by virtue of education, training or experience, provides treatment, which includes advice, opinion, or instruction to an individual or in a group setting to allow an opportunity for a person to explore the person’s problems related directly or indirectly to substance abuse, chemical dependence or problem gambling.

“Culturally and environmentally specific” means integrating into the assessment and treatment process the ideas, customs, beliefs, and skills of a given population, as well as an acceptance, awareness, and celebration of diversity regarding conditions, circumstances and influences surrounding and affecting the development of an individual or group.

“Deemed status” means that the committee and division will accept a committee-approved, outside accreditation body’s review, assessment and accreditation of a program, component or service of a program/organization’s operations and services. Programs which received deemed status approval are exempt from routine licensure requirements; however, such programs are subject to all other provisions of this chapter.

“Department” means the Iowa department of public health.

“Designee” means the staff person or counselor who is delegated tasks, duties and responsibilities normally performed by the treatment supervisor, treatment director or executive director.

“Detoxification” means the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner. ASAM-PPC-2R detoxification levels of care include Levels I-D, II-D, III.2-D, III.7-D, and IV-D.

“Director” means the director of the Iowa department of public health.

“Discharge planning” means the process, begun at admission, of determining a client/patient’s continued need for treatment services and of developing a plan to address ongoing client/patient posttreatment needs. Discharge planning may or may not include a document identified as a discharge plan.

“Division” means the division of behavioral health.

“Emergency admission” means an admission due to an emergency situation with placement screening criteria being applied as soon after admission as possible.

“Emotional, behavioral or cognitive conditions and complications” is a category to be considered in the ASAM-PPC-2R criteria. This category evaluates client/patient’s current emotional, behavioral, and cognitive status. Emotional, behavioral or cognitive status may include, but is not limited to, psychiatric conditions, psychological or emotional/behavioral complications, poor impulse control, changes in mental status, or transient neuropsychiatric complications and the behavior that accompanies or follows these emotional states. Historical information on client/patient’s emotional/behavioral functioning may also be considered.

“Evaluation” means the process to evaluate the client/patient’s strengths, weaknesses, problems, and needs for the purpose of defining a course of treatment. This includes use of the standardized placement screening and any additional client/patient profile information and development of a comprehensive treatment plan.

“Extended outpatient treatment” means a Level I service of the ASAM-PPC-2R criteria, which is an organized, nonresidential service. Extended outpatient treatment services usually are provided in regularly scheduled sessions which include less than nine treatment hours a week for adults or less than six treatment hours a week for adolescents. For problem gambling client/patients, extended outpatient treatment services may be offered in conjunction with transitional housing.

“Facility” means a hospital, detoxification center, institution or program licensed under Iowa Code section 125.13 or 2009 Iowa Code Supplement section 135.150 providing care, maintenance and

treatment for client/patients. Facility also includes the physical areas such as grounds, buildings, or portions thereof under direct administrative control of the program.

“Focused reviews” means a survey conducted during the licensing process to assess the degree to which a program has improved its level of compliance relating to specific recommendations. The subject matter of the review is typically in area(s) of identified deficiency in compliance; however, other performance areas may also be assessed by a surveyor(s), including areas not covered in deemed status.

“Follow-up” means the process for determining the status of an individual who has been referred to an outside resource for services or who has been discharged from services.

“Governing body” means the individual(s), group, or agency that has ultimate authority and responsibility for the overall operation of the facility.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996.

“Intake” means gathering additional assessment information at the time of admission to services.

“Intensive outpatient treatment (Level II.1)” means intensive outpatient programs (IOP) that provide a minimum of nine hours for adults or a minimum of six hours for adolescents of structured programming per week, consisting primarily of counseling and education. For problem gambling client/patients, the service may be offered in conjunction with transitional housing.

“Iowa board of certification” means the professional certification board that certifies substance abuse counselors and prevention specialists, problem gambling treatment specialists and other addiction treatment specialists in the state of Iowa.

“Levels of care” is a general term that encompasses the different options for treatment that vary according to the intensity of the services offered. Each treatment option in the ASAM-PPC-2R is a level of care.

“Licensee” means any program licensed by the department.

“Licensure” means the issuance of a license by the department and the committee which validates the licensee’s compliance with treatment program standards and authorizes the licensee to operate a treatment program in the state of Iowa.

“Licensure weighting report” means the report that is used to determine the type of license a program qualifies for based on point values assigned to areas reviewed and total number of points attained. In addition, a minimum percent value in each of three categories shall be attained to qualify a program for a license as follows: 95 percent or better rating in clinical, administrative and programming for a three-year license; 90 percent or better rating in clinical, administrative and programming for a two-year license; or less than 90 percent but no less than 70 percent rating in clinical, administrative and programming for a one-year license. The determination of length of license for programs licensed through deemed status shall be made by the accreditation body.

“Maintenance” means the prolonged scheduled administration of methadone or other approved controlled substances intended as a substitute or antagonist to abused substances in accordance with federal and state regulations.

“Management of care” means the process to ensure the appropriate level of care is utilized by implementing ASAM-PPC-2R criteria during placement screening, continuing service and discharge. This process includes discharge planning that begins at admission to meet the immediate, ongoing and posttreatment needs of the client/patient.

“May” means a term used in the interpretation of a standard to reflect an acceptable method that is recognized but not necessarily preferred.

“Medically managed intensive inpatient treatment (Level IV)” is an organized ASAM-PPC-2R service staffed by designated addiction physicians or addiction credentialed clinicians. Level IV care involves a planned regimen of 24-hour medically directed evaluation, care and treatment of substance-related disorders in an acute-care inpatient setting. Such a service functions under a defined set of policies and procedures and has permanent facilities that include inpatient beds. Services involve daily medical care in which diagnostic and treatment services are directly provided by a licensed physician.

“Medically monitored intensive inpatient treatment (Level III.7)” is an organized ASAM-PPC-2R service delivered by an interdisciplinary staff to client/patients whose subacute biomedical and

emotional/behavioral problems are sufficiently severe to require inpatient care. Twenty-four-hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed inpatient treatment service system are not necessary. Services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists and other health care professionals and technical personnel, under the direction of licensed physicians. Medical monitoring is provided through an appropriate mix of direct patient contact, review of records, team meetings, 24-hour coverage by a physician, and quality assurance programs.

“Outreach” means public speaking engagements and other similar activities and functions that inform the public of available programs and services offered by a treatment program. In addition, outreach is a process or series of activities that identifies individuals in need of services, engages them and links them with the most appropriate resource or service provider. Such activities may include, but are not limited to, the following: individual client/patient recruitment through street outreach and organized informational sessions at churches, community centers, recreational facilities, and community service agencies.

“OWI” means operating while intoxicated, in violation of Iowa Code chapter 321J.

“Partial hospitalization (day treatment) (Level II.5)” means a program which provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical and laboratory services and thus are better able than Level II.1 programs to meet client/patient needs. Partial hospitalization/day treatment is a generic term encompassing day, night, evening and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatments.

“Physician” means any individual licensed under Iowa Code chapter 148, 150, or 150A.

“Prevention” means a proactive process to eliminate unnecessary disease, disability, and premature death caused by (1) acute disease, (2) chronic disease, (3) intentional or unintentional injury or disease associated with environmental, home and workplace hazards, and (4) controllable risk factors such as poor nutrition; lack of exercise; alcohol, tobacco, and other drug use; inadequate use of preventive health services; and other risk behaviors.

“Primary care modality” means a treatment component or modality including continuing care, halfway house, extended outpatient treatment, intensive outpatient treatment, primary extended residential treatment, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment services.

“Primary scope of practice” means the area in which a counselor maintains a professional license or certification.

“Prime programming time” means any period of the day when special attention or supervision is necessary, for example, upon awakening in the morning until departure for school, during meals, after school, transition between activities, evenings and bedtime, or weekends and holidays, in order to maintain continuity of program and care. Prime programming time shall be defined by the facility.

“Problem gambling” means a pattern of gambling behavior which may compromise, disrupt or damage family, personal or vocational pursuits.

“Program” means any partnership, corporation, association, governmental subdivision or public or private organization.

“Protected classes” means classes of people who have required special legislation to ensure equality.

“Quality improvement” means the process of objectively and systematically monitoring and evaluating the quality and appropriateness of client/patient care to improve client/patient care and resolve identified problems.

“Readiness to change” is a category to be considered in the ASAM-PPC-2R criteria. This category evaluates the client/patient’s current emotional and cognitive awareness of the need to change and level of commitment to change.

“Recovery/living environment” is a category to be considered in the ASAM-PPC-2R criteria. This category evaluates client/patient’s current recovery/living environment as it impacts on level of care decision making and treatment planning. Recovery/living environment may include, but is not limited to, current relationships and degree of support for recovery, current housing, employment situation, and

availability of alternatives. Historical information on client/patient's recovery/living environment may also be considered.

"Recovery oriented system of care" means person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness, and recovery from mental illness, alcohol and drug problems, and problem gambling. A recovery oriented system of care offers a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery.

"Rehabilitation" means the restoration of a client/patient to the fullest physical, mental, social, vocational, and economic usefulness of which the client/patient is capable. Rehabilitation may include, but is not limited to, medical treatment, psychological therapy, occupational training, job counseling, social and domestic rehabilitation and education.

"Relapse" means progressive irresponsible, inappropriate and dysfunctional behavior patterns that could lead to resumption of alcohol or drug use or problem gambling. "Relapse" also refers to the resumption of alcohol or drug use or problem gambling.

"Relapse, continued-use or continued-problem potential" is a category to be considered in the ASAM-PPC-2R criteria. This category evaluates client/patient's current factors that contribute to relapse potential as it impacts on level of care decision making and treatment planning. Relapse potential may include, but is not limited to, current statements by client/patient about relapse potential, reports from others on potential for client/patient's relapse, and assessment by clinical staff. Historical information on client/patient's relapse potential may also be considered. This category may include the client/patient's understanding of skills in coping with addictive or mental disorders, recognition of relapse triggers, skills to control impulses and ways to cope with relapse potential.

"Residential program" means a 24-hour, live-in, seven-day-a-week treatment program facility offering intensive rehabilitation services to individuals who are considered unable to live or work in the community due to social, emotional, or physical disabilities resulting from substance abuse or problem gambling. The ASAM-PPC-2R levels of care may include III.1, III.3, III.5 or III.7.

"Rule" means each statement of general applicability that implements, interprets, or prescribes division law or policy, or that describes the organization procedure or practice requirements of the division. The term includes the amendment or repeal of existing rules as specified in the Iowa Code.

"Screening" means the process by which a client/patient is determined appropriate and eligible for admission to a particular program or level of care. The focus is on the minimum criteria necessary for appropriateness/eligibility.

"Self-administration of medication" means the process where a properly trained staff member observes a client/patient inject, inhale, ingest, or by any other means take, medication which has been prescribed by a licensed physician.

"Shall" means the term used to indicate a mandatory statement, the only acceptable method under the present standards.

"Should" means the term used in the interpretation of a standard to reflect the commonly accepted method, yet allowing for the use of effective alternatives.

"Sole practitioner" means an individual incorporated under the laws of the state of Iowa, or an individual in private practice who is providing substance abuse treatment services independent from a program that is required to be licensed in accordance with Iowa Code section 125.13(1).

"Specialized certification" means a substance abuse- or problem gambling-related credential acceptable to the department for providing treatment according to these rules.

"Staff" means any individual who provides services to the treatment program on a regular basis as a paid employee, agent or consultant or as a volunteer.

"Standards" means specifications representing the minimal characteristics of a treatment program which are acceptable for the issuance of a license.

"Subspecialty" means a secondary scope of practice, either substance abuse treatment or problem gambling treatment, approved in accordance with these rules. To maintain expertise within the

subspecialty, the counselor shall complete a minimum of an additional 20 hours of training within the subspecialty every two years.

“*Substance abuser*” means a person who habitually lacks self-control as to the use of chemical substances or uses chemical substances to the extent that the person’s health is substantially impaired or endangered or that the person’s social or economic function is substantially disrupted.

“*Time frames*” means the period of time within which the assessment and treatment plan must be completed after admission, frequency of review of the treatment plan by the client/patient and counselor, and frequency of reviews for continuing service and discharge. The time frames for Levels I and III.1 shall be every 30 days; for Levels II.1, II.5, III.3 and III.5, every 7 days; and for Levels III.7 and IV, daily. For Level I continuing care/aftercare, there shall not be any required frequency of review for continuing service or frequency of review of treatment plan by client/patient and counselor.

“*Transitional housing*” means housing that may be offered to individuals who are problem gamblers and who have no other housing alternatives or whose housing alternatives are not conducive to problem gambling recovery. Problem gamblers receiving transitional housing must also be receiving problem gambling treatment services.

“*Treatment*” means the broad range of planned and continuing inpatient, outpatient, and residential care services, including diagnostic evaluation, counseling, and medical, psychiatric, psychological, and social service care, which may be extended to substance abusers, problem gamblers, concerned persons, concerned family members, or significant others. Treatment is geared toward influencing the behavior of such individuals to achieve a state of rehabilitation.

“*Treatment days*” means days in which the treatment program is open for services or actual working days.

“*Treatment planning*” means the process by which a counselor and client/patient identify and rank problems, establish agreed-upon goals, and decide on the treatment process and resources to be utilized.

“*Treatment program*” means a program licensed under these rules. A treatment program may be a substance abuse treatment program, a problem gambling treatment program, or a substance abuse and problem gambling treatment program.

“*Treatment supervisor*” means an individual who, by virtue of education, training or experience, is capable of assessing the psychosocial history of a client/patient to determine the treatment plan most appropriate for the client/patient. This person shall be designated by the treatment program.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.2(125,135) Licensing. A single license will be issued to each qualifying treatment program. A program shall apply for a license to provide substance abuse treatment, problem gambling treatment, or combined substance abuse and problem gambling treatment.

155.2(1) Categories of services. The license will delineate one or more categories of services the program is authorized to provide. Although a program may have more than one facility, only one license will be issued to the program. The categories of services for which licenses will be issued are:

- a. Narcotic detoxification/chemical substitute, antagonist maintenance chemotherapy;
- b. Assessment and evaluation;
- c. OWI correctional residential;
- d. OWI correctional outpatient;
- e. Correctional residential treatment;
- f. Correctional outpatient treatment;
- g. Medically managed intensive inpatient services: Level IV;
- h. Residential/inpatient services: Levels III.1, III.3, III.5 and III.7;
- i. Intensive outpatient/partial hospitalization services: Levels II.1 and II.5; and
- j. Outpatient extended and continuing care services: Level I.

155.2(2) Licensing body. The committee shall:

- a. Consider and approve or disapprove all applications for a license and all cases involving the renewal, denial, suspension, or revocation of a license;

b. Advise the department on policies governing the performance of the department in the discharge of any duties imposed on the department by law;

c. Advise or make recommendations to the board relative to substance abuse and gambling treatment, intervention, education, and prevention programs in this state; and

d. Perform other duties as assigned by the board.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.3(125,135) Type of licenses.

155.3(1) Issuance of licenses.

a. Licenses may be issued for up to three years. A license may be renewed for one, two, or three years. An initial license may be issued for 270 days. A license issued for 270 days shall not be renewed or extended.

b. Licenses shall expire one or two calendar years from the date of issue, and a renewal of the license shall be issued only on application.

c. The renewal of a one-year or two-year license shall be contingent upon demonstration of continued compliance with licensure standards and in accordance with the licensure weighting report criteria.

d. The renewal of a three-year license shall be contingent upon demonstration of substantial continued compliance with licensure standards and in accordance with the licensure weighting report criteria or continuation in deemed status.

e. Failure to apply for renewal of the license within 30 days after the expiration date shall result in immediate termination of license and require reapplication.

155.3(2) Corrective action. Following the issuance of a license, the treatment program may be requested by the committee to provide a written plan of corrective action and to bring into compliance all areas found in noncompliance during the on-site visit. The corrective action plan shall be placed in the program's permanent file with the division and used as reference during future on-site inspections.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.4(125,135) Nonassignability; program closure.

155.4(1) A license issued by the department for the operation of a treatment program applies both to the applicant program and the premises upon which the program is to be operated. Licenses are not transferable.

155.4(2) A discontinued program is one which has terminated the services for which it has been licensed. When a program is discontinued, its current license is void immediately and shall be returned to the department.

155.4(3) Any person or other legal entity acquiring a licensed facility for the purpose of operating a treatment program shall apply for a new license.

155.4(4) Any person or legal entity having acquired a license and desiring to fundamentally alter the treatment philosophy or transfer to a different premises must notify the committee 30 days prior to said action in order for the department to review the site change and to determine appropriate action.

155.4(5) A licensee shall, if possible, notify the department of impending closure of the licensed program at least 30 days prior to such closure. The licensee shall be responsible for the removal and placement of client/patients and for the preservation of all records. Upon closing all facilities and terminating all service delivery activities, the licensee shall immediately return the license to the department.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.5(125,135) Application procedures. The department shall provide an application to all applicants for licensure. An on-site visit for licensure of an initial applicant shall occur before the program opens and admits client/patients for services. For initial applicants, if technical assistance has been provided, the on-site visit may be waived at the discretion of the department. The division shall prepare a report with a recommendation for licensure to be presented at a committee meeting within 60 days from the site visit. Public notice for committee meetings will be made in accordance

with Iowa Code section 21.4. The division shall provide notice to the program ten days prior to the committee meeting notifying the program director and program board chairperson of the time, place, and date the committee will review and act upon the application for the program along with the results of the inspection. The division shall provide to all committee members reports of the on-site program licensure inspection and a final recommendation for each application to be acted upon at the next committee meeting.

155.5(1) *Application information for comprehensive programs.* An applicant for licensure shall submit the following information on forms available at the Iowa Department of Public Health, Division of Behavioral Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

- a. The name and address of the applicant treatment program.
- b. The name and address of the executive director of such treatment program.
- c. The names, titles, dates of employment, education, and years of current job-related experience of staff and a copy of the table of organization. Where multiple components and facilities exist, the relationship between components and facilities must be shown, as well as a description of the screening and training process for volunteer workers.
- d. The names and addresses of members of the governing body, sponsors, or advisory boards of such treatment program and current articles of incorporation and bylaws.
- e. The names and addresses of all physicians, other professionally trained personnel, medical facilities, and other individuals or organizations with whom the treatment program has a direct contractual or affiliation agreement.
- f. A description of the treatment services provided by the treatment program and a description of weekly activities for each treatment modality or component.
- g. Copies of reports substantiating compliance with federal, state and local rules and laws for each facility, to include appropriate Iowa department of inspections and appeals rules, state fire marshal's rules and fire ordinances, appropriate local health, fire, occupancy code, and safety regulations.
- h. Information required under Iowa Code section 125.14A.
- i. Fiscal management information to include a recent audit or opinion of auditor and program board minutes to reflect approval of budget and insurance program.
- j. Insurance coverage related to professional and general liability; building; workers' compensation; and fidelity bond.
- k. The address and facility code of each office, facility, or program location.
- l. The program's current written policies and procedures manual to include the staff development and training program, and personnel policies. Applications for licensure will not be considered complete until a complete policies and procedures manual has been submitted to the division.
- m. The application information for an initial application for licensure shall be complete and shall be reviewed by the department prior to a scheduled on-site inspection.

155.5(2) *Application information for substance abuse assessment and evaluation programs.* An applicant for licensure shall submit the following information on forms available at the Iowa Department of Public Health, Division of Behavioral Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

- a. The name and address of the applicant substance abuse assessment and evaluation program.
- b. The name and address of the executive director or sole practitioner of such substance abuse program.
- c. The names, titles, dates of employment, education, and years of current job-related experience of staff and a copy of the table of organization (if applicable). If multiple components and facilities exist, the relationship between components and facilities must be shown, as well as a description of services.
- d. The names and addresses of members of the governing body, sponsors, or advisory boards of such substance abuse assessment and evaluation program and current articles of incorporation and bylaws. (This requirement does not apply to a sole practitioner.)
- e. The name(s) and address(es) of person(s) entered into the affiliation agreement for clinical oversight.
- f. A description of the assessment and evaluation services.

g. Copies of reports substantiating compliance with federal, state and local rules and laws for each facility, to include appropriate state fire marshal's rules and fire ordinances, occupancy code, and safety regulations.

h. Information required under Iowa Code section 125.14A.

i. Insurance coverage related to professional and general liability; building; workers' compensation; and fidelity bond.

j. The address and facility code of each office, facility, or program location.

k. The program's current written policies and procedures manual which shall include the staff development and training program, and personnel policies. Applications for licensure will not be considered complete until a complete policies and procedures manual has been submitted to the division.

The application information for an initial application for licensure shall be complete and shall be reviewed by the department prior to a scheduled on-site inspection.

155.5(3) *Renewal.* An application for renewal shall be submitted on forms provided by the department at least 60 calendar days before expiration of the current license. An application for licensure renewal will not be considered complete until a current policies and procedures manual has been submitted to the department by the applicant treatment program.

155.5(4) *Application update or revision.* The department shall be notified, and a request of an application for licensure for update or revision shall be made, by an existing licensed program 30 days prior to any change(s) of address of offices, facilities, or program locations; or additions or deletions of the type(s) of services or programs provided and licensed. A new licensure application form shall be completed to reflect change of address of offices, facilities, or program locations, or additions or deletions of the type(s) of services or program(s) provided or licensed and shall be returned to the division within 10 working days from the date the forms are received. When applicable, as determined by the department, an on-site licensure inspection of a new component, service, program or facility may be conducted by the department within six months, upon receipt of the updated or revised application or during an existing licensed program's scheduled relicensure on-site inspection, whichever occurs first.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.6(125,135) *Application review.* An applicant for licensure shall submit a completed application to the department within 30 days from the date the forms are received. The department shall review the application for completion and request any additional material as needed.

Applicants failing to return the forms shall be notified by registered mail that all programs must be licensed.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.7(125,135) *Inspection of licensees.* The department shall inspect the facilities and review the policies and procedures utilized by each program. The examination and review may include case record audits and interviews with staff and clients, consistent with the confidentiality safeguards of state and federal laws.

155.7(1) *Technical assistance.* A program applying for an initial license to operate a treatment program in the state of Iowa will be visited by the department for the purpose of providing needed technical assistance regarding the licensure criteria and procedures. The program may waive technical assistance in order to expedite the licensing process. Requests shall be submitted in writing to the division.

a. Following the issuance of a license, the treatment program may request technical assistance from the department so as to bring into conformity areas reported to be in noncompliance to these rules. Such technical assistance shall be scheduled within 30 days of the applicant's request depending on the availability of staff. The department may also request that technical assistance be provided to the program if deficiencies are noted during a site visit.

b. Reserved.

155.7(2) *On-site visit for licensure.* A licensure on-site inspection shall be scheduled after the department's receipt of the program's application to operate a treatment program. The department shall not be required to provide advance notice to the program of the on-site visit for licensure.

a. The on-site visit team will consist of designated members of the division staff, as approved by the director.

b. The team will inspect the program in order to verify information contained in the application and ensure compliance with all laws, rules and regulations.

c. The inspection team shall send a written report, return receipt requested, of their findings to the applicant within 20 working days after the completion of the inspection.

155.7(3) Effective date of license. The effective date of a license shall begin on the date the committee reviews the program's written report/application and acts to issue a license.
[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.8(125,135) Licenses—renewal. Upon approval of an application for licensing by the committee, a license shall be issued by the department. Licenses shall be renewed pursuant to rule 641—155.5(125,135).

155.8(1) Committee meeting preparation. The division shall prepare a report with a final recommendation for licensing to be presented at a committee meeting within 80 days from the site visit. Public notice of committee meetings shall be made in accordance with Iowa Code section 21.4.

a. The division shall send notice to the program by certified mail, return receipt requested, ten days prior to the committee meeting notifying the program director and program board chairperson of the time, place, and date the committee will review and act upon the application for the program along with the results of the inspection.

b. The division shall mail to all committee members the following information on each application to be processed at the next committee meeting:

- (1) Reports of the on-site program licensure inspections; and
- (2) A final recommendation for licensing.

155.8(2) Committee meeting format.

a. The chairperson or designee shall call the meeting to order at the designated time.

b. The presiding officer will read each application and protocols.

c. Opportunity shall be given all concerned parties to respond, present evidence, and arguments on each application.

d. After all concerned parties are heard, the committee will make a decision as to whether the applicant should be finally approved or initially denied a license to operate a substance abuse treatment program.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.9(125,135) Corrective action plan. Programs approved for a license for 270 days by the committee shall submit a corrective action plan to the director no later than 30 days following the committee meeting. The corrective action plan shall include, but not be limited to:

1. Specific problem areas.
2. A delineation of corrective measures to be taken by the program.
3. A delineation of target dates for completion of corrective measures for each problem area.
4. A follow-up on-site visit will be required to review the implemented corrective action with a subsequent report to the committee.

Programs issued a license for a period of one or two years shall submit a corrective action plan for those standards found to be in noncompliance following a licensure inspection. Technical assistance on a corrective action plan shall not be required for one- or two-year licenses. The corrective action plan shall be submitted within 30 days of receipt of the licensure inspection report.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.10(125,135) Grounds for denial of initial license.

155.10(1) Denial of application for licensure. All programs applying for an initial license shall submit complete application information and shall be inspected by the department prior to the program's opening and offering services. A recommendation by the department of a denial of an initial application for licensure to the committee may be made based on the following reasons:

a. The application for licensure is incomplete or does not have the information required by 641—155.5(125).

b. On-site inspection report results based on the licensure weighting report indicate a score below minimum required for a recommendation of a 270-day license. A program applying for a 270-day license shall have a minimum score of 70 percent in each of the following standards: clinical, administrative and programming.

c. Violation of any of the grounds for discipline pursuant to 641—155.11(125,135).

155.10(2) *On-site visit for licensure.* The on-site visit for licensure of an initial applicant shall occur prior to the program opening and admitting client/patients. The department shall not be required to provide advance notice to the program of the on-site visit for licensure.

a. The on-site visit team will consist of designated members of the division staff, as approved by the director.

b. The team will inspect the program that has applied for a license in order to verify information contained in the application, ensure compliance with all laws, rules and regulations.

c. The inspection team shall send a written report, return receipt requested, of their findings to the applicant within 20 working days after the completion of the inspection.

d. The application information for an initial application for licensure shall be complete and shall be reviewed by the department prior to a scheduled on-site inspection.

155.10(3) *Committee action.* The committee shall meet to consider all cases involving issuance of a license. Upon approval of an application for licensure by the committee, a license shall be issued by the department.

a. *Committee hearing preparation.* The division will prepare all documents with a final recommendation for licensing determination to be presented at a committee meeting within 120 days from the site visit. The division shall provide public notice of the date, time, and place of the meeting and the names of applicants to be reviewed and processed.

(1) The division shall provide notice to the program 30 days prior to the committee meeting notifying the program director and program board chairperson of the time, place, and date the committee will review and act upon the application for the program along with the results of the inspection.

(2) The division shall provide to all committee members the following information on each application to be processed at the next committee meeting: reports of the on-site program licensure inspections, and a final recommendation for licensing.

b. *Committee meeting format.*

(1) The chairperson or designee shall call the meeting to order at the designated time.

(2) The presiding officer or designee shall give summary of each application and protocols.

(3) Opportunity shall be given all concerned parties to respond and present evidence and arguments on each application.

(4) After all concerned parties are heard, the committee will make a decision as to whether the applicant should be finally approved or initially denied a license to operate a substance abuse treatment program.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.11(125,135) Suspension, revocation, or refusal to renew a license.

155.11(1) The committee may suspend or revoke a license or refuse to renew a license for any of the following reasons:

a. Failure to adequately complete the application or renewal application process or submission of fraudulent or misleading information in the application or renewal process.

b. Failure to obtain the minimum score required for a one-, two- or three-year license.

c. Violation by a program, program employee or agent of any statute or rule pertaining to treatment programs, including a violation of any provision of this chapter.

d. Failure to comply with licensure, inspection, health, fire, occupancy, safety, sanitation, zoning, or building code or regulations required by federal, state, or local law.

- e.* Receiving a report from an accreditation body sanctioning, modifying, terminating, or withdrawing the accreditation of the program.
- f.* Suspension, revocation, refused renewal, or refused issuance of a federal registration to distribute or dispense methadone or other controlled substances.
- g.* Committing or permitting or aiding or abetting the commission of an unlawful act within a facility.
- h.* Conviction of a member of the governing body, a director, administrator, chief executive officer, or other managing staff member, of a felony or misdemeanor involving the management or operation of the facility or which is directly related to the operation or integrity of the facility.
- i.* Use of untruthful or improbable statements in advertising.
- j.* Conduct or practices found by the committee to be detrimental to the general health, safety, or welfare of a client/patient or member of the general community.
- k.* Violating a client/patient's confidentiality or willful, substantial, or repeated violations of a client/patient's rights.
- l.* Defrauding a client/patient, potential client/patient, or third-party payor.
- m.* Inappropriate conduct by program staff, including sexual or other harassment or exploitation of a program client/patient, volunteer, trainee or employee.
- n.* Utilization of treatment techniques which endanger the health, safety, or welfare of a client/patient.
- o.* Discrimination or retaliation against a client/patient or employee who has submitted a complaint or information to the department.
- p.* Failure to allow an employee or agent of the department access to the facility for the purpose of inspection, investigation, or other information collection duties necessary to the performance of the department's duties.
- q.* Failure to submit an acceptable written plan of corrective action or failure to comply with a written plan of corrective action issued pursuant to 155.3(2), 641—155.9(125,135), or 155.16(4) "e."
- r.* Violating an order of the committee or violating the terms or conditions of a consent agreement or informal settlement between a program and the committee.

155.11(2) Initial notice from committee. When the committee determines to deny a renewal, suspend or revoke a license, the committee shall notify the licensee by certified mail, return receipt requested, of the committee's intent to suspend, revoke, or refuse to renew the license and the changes that must be made in the licensee's operation to avoid such action. The initial notice shall further provide the licensee the opportunity to submit either a written plan of corrections or written objections to the department within 20 days from the receipt of notice from the committee.

155.11(3) Correction of issues or objections.

a. Written plan of corrections. If a licensee submits a written plan of corrections, the licensee shall have 60 days from the date of submission within which to show compliance with the plan of corrections. The licensee shall submit any information to the committee that the licensee deems pertinent to show compliance with the plan of corrections.

b. Objections. If a licensee submits written objections, the licensee shall submit to the committee any information that the licensee deems pertinent which supports the licensee's defense.

155.11(4) Decision of committee. Following receipt of a written plan of corrections and expiration of the 60-day time period, or following receipt of written objections, or when objections or notice of corrections have not been received within the 20-day time period, the committee may meet to determine whether to proceed with the disciplinary action. The licensee shall receive notice of this meeting in the same manner as provided by 155.8(1) "a."

155.11(5) Notice of decision and opportunity for contested case hearing.

a. When the committee determines to suspend, revoke or not renew a license, the licensee shall be given written notice by restricted certified mail.

b. The licensee may request a hearing on the determination. The request must be in writing and mailed to the department address within 30 days of the notice issued by the committee. The request shall

be sent by certified mail, return receipt requested. Failure to request a hearing will result in final action by the committee.

155.11(6) Summary suspension. If the committee finds that the health, safety or welfare of the public is endangered by continued operation of a treatment program, summary suspension of a license may be ordered pending proceedings for revocation or other actions. These proceedings shall be promptly instituted and determined.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.12(125,135) Contested case hearing. Programs that wish to contest the denial, suspension, revocation or refusal to renew their license shall be afforded an opportunity for a hearing before an administrative law judge from the Department of Inspections and Appeals. The program will be notified in writing, return receipt requested, of the date of the hearing, no less than 30 days before the hearing.

155.12(1) Failure to appear. If a party fails to appear in a contested case hearing proceeding after proper service of notice, the administrative law judge shall, in such a case, enter a default judgment against the party failing to appear.

155.12(2) Conduct of hearing. Opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense.

a. The hearing shall be informal and all relevant evidence admissible. Effect will be given to the rules of privilege recognized by law. Objections to evidentiary offers may be made and shall be noted in the record. When the hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be required to be submitted in verified written form.

b. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available. Upon request, parties shall be given an opportunity to compare the copy with the original, if available.

c. Witnesses present at the hearing shall be subject to cross-examination by any party as necessary for a full and true disclosure of the facts.

d. The record in a contested case shall include:

- (1) All pleadings, motions and intermediate rulings.
- (2) All evidence received or considered and all other submissions.
- (3) A statement of all matters officially noticed.
- (4) All questions and offers of proof, objections and rulings therein.
- (5) All proposed findings and exceptions.
- (6) Any decision, opinion or report by the officer presiding at the hearing.

e. Oral proceedings shall be open to the public and shall be recorded either by mechanized means or by certified shorthand reporters. Oral proceedings or any part thereof shall be transcribed at the request of any party with the expense of the transcription charged to the requesting party. The recording or stenographic notes of oral proceedings or the transcription thereof shall be filed with and maintained by the agency for at least five years from the date of decision.

f. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record.

155.12(3) Continuance. For good cause, the administrative law judge may continue hearings beyond the time originally scheduled or recessed. Requests for continuance shall be made to the administrative law judge in writing at least three days prior to the scheduled hearing date. Continuances will not be granted less than three days before the hearing except for exigent circumstances.

155.12(4) Decision. Findings of fact shall be based solely on the evidence in the record and upon matters officially noticed in the record.

a. The decision of the administrative law judge shall be the final decision unless there is an appeal to the board within 20 days of the receipt of the decision.

b. A proposed or final decision or order in a contested case hearing shall be in writing. A proposed or final decision shall include findings of fact and conclusions of law, separately stated. Parties will be promptly notified of each proposed or final decision or order by the delivery to them of a copy of such

decision or order by certified mail, return receipt requested. In the case of a proposed decision, parties shall be notified of the right to appeal the decision to the board.

155.12(5) Appeal to the board.

a. Either party may request the board review the proposed decision. The request shall be in writing and mailed within 20 days of receipt of the proposed decision.

b. The parties shall have an opportunity to submit briefs to the board. The board will review the record and any briefs. No new evidence shall be admitted unless requested and allowed by the board.

c. Oral presentation will be made to the board at a time set by the board.

d. The board shall issue its decision in writing within 30 days after conclusion of the hearing.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.13(125,135) Rehearing application. Any party may file an application for rehearing, stating the specific grounds therefor and the relief sought, within 20 days after the issuance of any final decision by the board in a contested case. A copy of such application shall be timely mailed by the applicant to all parties of record not joining therein. Such an application for rehearing shall be deemed to have been denied unless the board grants the application within 20 days after its filing.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.14(125,135) Judicial review. A licensee who is aggrieved or adversely affected by the board's final decision and who has exhausted all adequate administrative remedies may seek judicial review of the board's decision pursuant to and in accordance with Iowa Code section 17A.19.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.15(125,135) Reissuance or reinstatement. After suspension, revocation or refusal to renew a license, the affected licensee shall not have the license reissued or reinstated within one year of the effective date of the suspension, revocation or expiration upon refusal to renew, unless by order of the committee. After that time, proof of compliance with the licensure standards must be presented to the committee prior to reinstatement or reissuance of a license.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.16(125,135) Complaints and investigations.

155.16(1) Complaints. Any person may file a complaint with the department against any program licensed pursuant to this chapter. The complaint shall be made in writing and shall be mailed or delivered to the division director at the Division of Behavioral Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075. A complaint form may be downloaded on-line at: http://www.idph.state.ia.us/bh/common/pdf/substance_abuse/complaint_form.pdf. The complaint shall include the name and address of the complainant, the name of the program, and a concise statement of the allegations against the program, including the specific alleged violations of Iowa Code chapter 125 or this chapter, if known. A complaint may also be initiated upon the committee's own motion pursuant to evidence received by the department. Timely filing of complaints is required in order to ensure the availability of witnesses and to avoid initiation of an investigation under conditions which may have been significantly altered during the period of delay.

155.16(2) Evaluation and investigation. Upon receipt of a complaint, the department shall make a preliminary review of the allegations contained in the complaint. Unless the department concludes that the complaint is intended solely to harass a program or lacks a reasonable basis, it shall conduct an on-site investigation of the program which is the subject of the complaint as soon as is practicable. The program which is the subject of the complaint shall be given an opportunity to informally respond to the allegations contained in the complaint either in writing or through a personal interview or conference.

155.16(3) Investigative report. Within 30 working days after completion of the investigation, the department shall prepare a written investigative report and shall submit the report to the executive director of the program, the chairperson of the governing body, and the committee. This report shall include the nature of the complaint and shall indicate if the complaint allegations were substantiated, unsubstantiated,

or undetermined, the basis for the finding, the specific statutes or rules at issue, a response from the program, if received, and a recommendation for action.

155.16(4) Review of investigations. The committee shall review the investigative report at its next regularly scheduled meeting and shall determine appropriate action.

a. Closure. If the committee determines that the allegations contained in the complaint are unsubstantiated, the committee shall close the case and shall promptly notify the complainant and the program by letter.

b. Referral for further investigation. If the committee determines that the case warrants further investigation, it shall refer the case to the department for further investigation.

c. Written plan of corrective action. If the committee determines that the allegations contained in the complaint are substantiated and corrective action is warranted, the committee may require the program to submit and comply with a written plan of corrective action. A program shall submit a written plan of corrective action to the department within 20 working days after receiving a request for such plan. The written plan of corrective action shall include a plan for correcting violations as required by the committee and a time frame within which such plan shall be implemented. The plan is subject to department approval. Requiring a written plan of corrective action is not formal disciplinary action. Failure to submit or comply with a written plan of corrective action may result in formal disciplinary action against the program.

d. Disciplinary action. If the committee determines that the allegations contained in the complaint are substantiated and disciplinary action is warranted, the committee may proceed with such action in accordance with rule 641—155.11(125).

155.16(5) Confidential information and public information. Information contained in a complaint may be confidential pursuant to Iowa Code section 22.7(2), 22.7(18), or 125.37 or any other provision of state or federal law. Investigative reports, written plans of corrective action, and all notices and orders issued pursuant to rule 641—155.11(125,135) shall refer to client/patients by number and shall not include any other client/patient identifying information. Investigative reports, written plans of corrective action, and all notices and orders issued pursuant to rule 641—155.11(125,135) shall be available to the public as open records pursuant to Iowa Code chapter 22.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.17 Reserved.

641—155.18(125,135) Deemed status. The committee shall grant deemed status to programs accredited either by a recognized national or not-for-profit accreditation body when the committee determines that the accreditation is for the same services. Problem gambling treatment components shall not be granted deemed status under this rule, unless specifically reviewed by the accreditation body.

155.18(1) National accreditation bodies. The national accreditation bodies currently recognized as meeting committee criteria for possible deemed status are:

- a.* Joint Commission.
- b.* Council on Accreditation of Rehabilitation Facilities (CARF).
- c.* Council on Accreditation of Children and Family Services (COA).
- d.* American Osteopathic Association (AOA).

155.18(2) Credentials and expectations of accreditation bodies.

a. The accreditation credentials of the bodies shall specify the types of organizations, programs and services the bodies accredit and targeted population groups, if appropriate.

b. Deemed status means that the committee and division shall recognize, in lieu of their own review, an outside body's review, assessment, and accreditation of a hospital-based or freestanding community-based treatment program's operations, functioning, and services that correspond to those described in this chapter.

155.18(3) Responsibilities of programs granted deemed status.

a. When a program receives accreditation and is then granted licensure through deemed status, the program shall continue to be responsible for meeting all requirements in accordance with this chapter and all applicable laws and regulations.

b. If a program that is nationally accredited requests deemed status for services not covered by the national accreditation body's standards, but covered by this chapter, the licensing for those services shall be conducted by the division.

c. Copies of the entire CARF, Joint Commission, COA, or AOA behavioral health accreditation survey/inspection report and certificate of accreditation shall be submitted to the division with the application for deemed status provided by the division.

d. A program shall submit to the division accreditation corrective plans or written conditions to accreditation.

e. A program shall be currently accredited by a committee-approved national accreditation body for services that are outlined in this chapter.

f. A program shall advise the division of any changes in the program's accreditation status, address, executive director/CEO, facility locations, or any other changes to the program/organization within 30 days of such change.

g. All survey reports for the hospital-based or freestanding community-based treatment program from the accrediting or licensing body shall be sent to the division.

h. For a program granted deemed status, the period of deemed status shall coincide with the period of time that program is awarded accreditation by the national accreditation body. However, under no circumstances shall it be longer than three years.

155.18(4) The committee and division shall retain the following responsibilities and rights when deemed status is granted to program/organizations:

a. The division may conduct site follow-up visits as determined appropriate.

b. The division shall investigate all complaints that are under the authority of this chapter and recommend and require corrective action or other sanctions in accordance with 641—155.16(125,135). All complaints, findings, and required corrective action may be reported to the accreditation body.

c. The committee shall review and act upon deemed status if necessary when complaints have been founded, when national accreditation bodies find instances of noncompliance with accreditation, when the accreditation status of the program expires without renewal, when the program's accreditation status is downgraded or withdrawn by the accreditation body, or when focused reviews find instances of noncompliance.

155.18(5) *Continuation of deemed status.* The program shall submit a copy of all CARF, Joint Commission, COA, or AOA behavioral health accreditation survey reports to the division. Applications for continuation of deemed status shall be submitted pursuant to 155.5(3).

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.19(125,135) Funding. The issuance of the license to any program shall not be construed as a commitment on the part of either the state or federal government to provide funds to such licensed program.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.20(125,135) Inspection. Each applicant or licensee agrees as a condition of licensure:

155.20(1) To permit properly designated representatives of the department to enter into and inspect any and all premises of programs for which a license has been either applied or issued to verify information contained in the application or to ensure compliance with all laws, rules, and regulations relating thereto, during all hours of operation of said facility and at any other reasonable hour.

155.20(2) To permit properly designated representatives of the department to audit and collect statistical data from all records maintained by the licensee. A facility shall not be licensed which does not permit inspection by the department or examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the committee deems relevant to the establishment of such a system.

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

641—155.21(125,135) General standards for all treatment programs. The following standards shall apply to all treatment programs in the state of Iowa regardless of the category of treatment services provided by such programs. In situations where differences between general standards for all treatment programs and specific standards occur, both general and specific standards must be met.

155.21(1) Governing body. Each program shall have a formally designated governing body that is representative of the community being served, complies with Iowa Code chapter 504, and is the ultimate authority for the overall program operations. Persons in private practice as sole practitioners shall be exempt from this subrule except for requirements to have malpractice and liability insurance.

a. The governing body shall develop and adopt written bylaws and policies that define the powers and duties of the governing body, its committees, advisory groups, and the executive director. These bylaws shall be reviewed and revised by the governing body as necessary.

b. The bylaws shall minimally specify the following:

- (1) The type of membership;
- (2) The term of appointment;
- (3) The frequency of meetings;
- (4) The attendance requirements; and
- (5) The quorum necessary to transact business.

c. Minutes of all meetings shall be kept and be available for review by the department and shall include, but not necessarily be limited to:

- (1) Date of the meeting;
- (2) Names of members attending;
- (3) Topics discussed; and
- (4) Decisions reached and actions taken.

d. The duties of the governing body shall include, but not necessarily be limited to, the following:

- (1) Appointment of a qualified executive director who shall have the responsibility and authority for the management of the program in accordance with the governing body's established policies;
- (2) Establish an effective control which will ensure that quality services are delivered;
- (3) Review and approve the program's annual budget; and
- (4) Approve all contracts.

e. The governing body shall develop and approve policies for the effective operation of the program.

f. The governing body shall be responsible for all funds, equipment, supplies and the facility in which the program operates. The governing body shall be responsible for the appropriateness and adequacy of services provided by the program.

g. The governing body shall at least annually prepare a report which will include, but not necessarily be limited to, the following items:

- (1) The name, address, occupation, and place of employment of each governing body member;
- (2) Any family relationships which a member of the governing body may have to a program staff member; and
- (3) Where applicable, the name and address of all owners or controlling parties whether they are individuals, partnerships, corporation body, or subdivision of other bodies, such as a public agency, or religious group, fraternity, or other philanthropic organization.

h. The governing body shall assume responsibility in seeing that the program has malpractice and liability insurance and a fidelity bond.

155.21(2) Executive director. This individual shall have primary responsibility for the overall program operations. The duties of the executive director shall be clearly defined by the governing authority, when applicable, in accordance with the policies established by the governing body.

155.21(3) Clinical oversight. The program shall have appropriate clinical oversight to ensure quality of clinical services provided to client/patients. This may be provided in-house or through consultation.

Clinical oversight may include assisting the program in developing policies and procedures relating to the assessment and treatment of psychopathology, assisting in the training of the staff and providing

assistance to the clinical staff in assessment or treatment. The executive director or designee shall be ultimately responsible for clinical services and implementation of treatment services to client/patients.

155.21(4) Staff development and training. There shall be written policies and procedures that establish staff development. Staff development shall include orientation for staff and opportunities for continuing job-related education. For corporations organized under Iowa Code chapter 496C and sole practitioners, documentation of continuing education to maintain professional license or certification as specified in 155.21(8) will meet the requirements of this subrule.

a. Evidence of professional education, certification as specified in 155.21(8), licensing, or orientation which includes the following: psychosocial, medical, pharmacological, confidentiality, and tuberculosis and blood-borne pathogens; an orientation to the program and community resources; counseling skill development; HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) information/education; and the attitudes, values and lifestyles of racially diverse cultures, other cultures and special populations.

b. The program shall establish on-site training programs or enter into relationships with outside resources capable of meeting staff training needs.

c. The staff development program shall take steps to ensure that staff members are kept informed of new developments in the field of assessment, evaluation, placement, treatment and rehabilitation.

d. In-service training programs shall be instituted when program operations or functions are changed and shall be designed to allow staff members to develop new skills so that they may effectively adapt to such changes.

e. Staff development activities and participation in state, national and regional training shall be planned and scheduled. These activities shall be documented in order to evaluate their scope, effectiveness, attendance, and amount of time spent on such efforts. The written plan for on-site staff development and activities for professional growth and development of personnel shall be based on the annual needs assessment and shall be available to all personnel.

f. Minutes shall be kept of on-site training activities and shall include, but not necessarily be limited to:

- (1) Date of the meeting;
- (2) Names of persons attending; and
- (3) Topics discussed, to include name and title of presenters.

g. The individual responsible for supervising staff development activities shall conduct at least an annual needs assessment.

155.21(5) Management information system. Programs receiving Medicaid or state funding and programs performing OWI evaluations in accordance with 641—Chapter 157 shall submit client/patient data to the Iowa Department of Public Health, Division of Behavioral Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075, in accordance with reporting system procedures.

155.21(6) Procedures manual. All programs shall develop and maintain a procedures manual. This manual shall define the program's policies and procedures to reflect the program's activities. Revisions shall be entered with the date, name and title of the individual making the entries. This manual shall contain all of the required written policies, procedures, definitions, and all other documentation outlined throughout these standards. The manual shall contain a working table of contents covering all policies and procedures mandated by this chapter.

155.21(7) Fiscal management. The program shall ensure proper fiscal management which shall include the following:

a. The preparation and maintenance of an annual written budget which shall be reviewed and approved by the governing body prior to the beginning of the budget year.

b. The fiscal management system shall be maintained in accordance with generally accepted accounting principles, including internal controls to reasonably protect agency assets. This shall be verified by an independent fiscal audit of the program by the state auditor's office or certified public accountant based on an agreement entered into by the governing body. An annual fiscal audit shall not be required for programs with an annual budget of \$75,000 or less.

c. There shall be an insurance program that provides for the protection of the physical and financial resources of the program which provides coverage for all people, buildings, and equipment. The insurance program shall be reviewed annually by the governing body.

d. Assessment and evaluation programs shall make public the OWI evaluation fees, and the client/patient shall be informed of the fee at the time of scheduling the appointment for the evaluation.

155.21(8) Personnel. Written personnel policies and procedures shall be developed by all programs except for sole practitioners. All program staff shall subscribe to a code of conduct found in professional certification or licensure as specified in 155.21(8).

a. All programs shall have written policies and procedures that address the following areas:

- (1) Recruitment, selection, and certification of staff members;
- (2) Recruitment and selection of volunteers;
- (3) Wage and salary administration;
- (4) Promotions;
- (5) Employee benefits;
- (6) Working hours;
- (7) Vacation and sick leave;
- (8) Lines of authority;
- (9) Rules of conduct;
- (10) Disciplinary actions and termination of employees;
- (11) Methods for handling cases of inappropriate client/patient care;
- (12) Work performance appraisal;
- (13) Employee accidents and safety;
- (14) Employee grievances; and
- (15) Policy on staff persons suspected of using or abusing substances.

b. The written personnel policies and practices shall include an equal employment opportunity policy and an affirmative action plan for hiring members of protected classes that minimally comply with Iowa civil rights commission rules and any local ordinances.

c. There shall be written job descriptions that reflect the actual duties of the employee.

d. Job descriptions shall accurately reflect the actual job situation and shall be reviewed when necessary by the executive director or whenever there is a change in required qualifications or duties.

e. All positions shall have job descriptions included in the personnel section of the procedures manual or personnel record of the staff member.

f. The written personnel policies and practices shall include a mechanism for written evaluation of personnel performance on at least an annual basis. There shall be evidence that this evaluation is reviewed with the employee and that the employee is given the opportunity to respond to this evaluation.

g. There shall be a personnel record kept on each staff member. These records shall contain as applicable:

- (1) Verification of training, experience, and all professional credentials relevant to the position;
- (2) Job performance evaluations;
- (3) Incident reports;
- (4) Disciplinary actions taken; and
- (5) Documentation of review and adherence to confidentiality laws and regulations. This review and agreement shall occur prior to assumption of duties.

h. There shall be written policies and procedures designed to ensure confidentiality of personnel records and a delineation of authorized personnel who have access to various types of personnel information.

i. Appropriately credentialed counselors.

(1) Any person providing screening, evaluations, assessments or treatment in accordance with this chapter shall meet at least one of the following conditions:

1. Currently maintain a substance abuse- or problem gambling-related credential acceptable to the department for providing treatment according to these rules.

2. Currently maintain active status as a licensed marital and family therapist (LMFT) licensed under Iowa Code chapters 154D and 147; a licensed mental health counselor (LMHC) licensed under Iowa Code chapters 154D and 147; a licensed independent social worker (LISW) licensed under Iowa Code chapters 154C and 147; or another licensed professional authorized by the Iowa Code to diagnose and treat DSM-IV disorders.

3. Currently maintain active status as a licensed master social worker (LMSW) licensed under Iowa Code chapters 154C and 147.

4. For a person beginning employment on or after July 1, 2010, at a program licensed in Iowa pursuant to this chapter who does not currently maintain one of the credentials described in “1” to “3” above, successfully complete and maintain one of those credentials within two years of the date on which the person begins to provide services.

5. Be employed before July 1, 2010, as a counselor at a program licensed in Iowa pursuant to this chapter. Those deemed qualified remain qualified only for work for that licensed program.

(2) Any person providing screening, evaluations, assessments or treatment in accordance with this chapter shall maintain a minimum of 30 hours of training within the person’s primary scope of practice every two years, including a minimum of three hours of ethics training. In addition to practicing within their primary scope of practice, certified or licensed personnel may practice within a subspecialty in accordance with this chapter by maintaining a minimum of an additional 20 hours of training within the subspecialty every two years.

j. There shall be written policies related to the prohibition of sexual harassment.

k. There shall be written policies related to the implementation of the Americans with Disabilities Act.

155.21(9) *Child abuse/dependent adult abuse/criminal history background check.*

a. Written policies and procedures shall prohibit mistreatment, neglect, or abuse of children and dependent adults and shall specify reporting and enforcement procedures for the program. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Written policies and procedures on reporting alleged violations regarding substance abuse client/patients shall be in compliance with HIPAA and DHHS, 42 CFR Part 2, regulations on Confidentiality of Alcohol and Drug Abuse Patient Records. Written policies and procedures on reporting alleged violations regarding problem gambling client/patients shall be in compliance with HIPAA and the Iowa Code. Any employee found to be in violation of Iowa Code sections 232.67 through 232.70, as substantiated by a department of human services’ investigation shall be subject to the program’s policies concerning dismissal.

b. For each employee working within a juvenile services area as set forth in Iowa Code section 125.14A or with dependent adults as set forth in Iowa Code chapter 235B, the personnel record shall contain at a minimum:

(1) Documentation of a criminal history background check with the Iowa division of criminal investigation on all new applicants for employment. The background check shall include asking whether the applicant has been convicted of a crime.

(2) A written, signed and dated statement furnished by a new applicant for employment which discloses any substantiated reports of child abuse, neglect or sexual abuse or dependent adult abuse.

(3) Documentation of a check after hiring on probationary or temporary status, but prior to permanently employing the individual, with the Iowa central registry for any substantiated reports of child abuse, neglect or sexual abuse pursuant to Iowa Code section 125.14A or substantiated reports of dependent adult abuse for all employees hired on or after July 1, 1994, pursuant to Iowa Code chapter 235B.

c. A person who has a record of a criminal conviction or founded child abuse report or founded dependent adult abuse report shall not be employed, unless an evaluation of the crime or founded child abuse or founded dependent adult abuse has been made by the department of human services which concludes that the crime or founded child abuse or founded dependent adult abuse does not merit prohibition of employment. If a record of criminal conviction or founded child abuse or founded dependent adult abuse does exist, the person shall be offered the opportunity to complete and submit

Form 470-2310, Record Check Evaluation. In its evaluation, the department of human services shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation and the number of crimes or founded abuses committed by the person involved.

d. Each treatment staff member shall complete two hours of training relating to the identification and reporting of child abuse and dependent adult abuse within six months of initial employment and at least two hours of additional training every five years thereafter.

155.21(10) *Client/patient case record maintenance.* There shall be written policies and procedures governing the compilation, storage and dissemination of individual client/patient case records.

a. These policies and procedures shall ensure that:

(1) The program exercises its responsibility for safeguarding and protecting the client/patient case record against loss, tampering, or unauthorized disclosure of information;

(2) Content and format of client/patient records are kept uniform; and

(3) Entries in the client/patient case record are signed and dated.

b. The program shall provide adequate physical facilities for the storage, processing, and handling of client/patient case records. These facilities shall include suitably locked, secured rooms or file cabinets.

c. Appropriate records shall be readily accessible to those staff members providing services directly to the client/patient and other individuals specifically authorized by program policy. Records should be kept in proximity to the area in which the client/patient normally receives services.

d. The program shall have a written policy governing the disposal and maintenance of client/patient case records. Client/patient case records shall be maintained for not less than seven years from the date they are officially closed.

e. Each file cabinet or storage area containing client/patient case records shall be locked.

f. The governing body shall establish policies that specify the conditions under which information on applicants or client/patients may be released and the procedures to be followed for releasing such information. Even if a program is not federally funded, all such policies and procedures regarding substance abuse client/patients shall be in accordance with HIPAA and the federal confidentiality regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," 42 CFR Part 2, effective June 9, 1987, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse client/patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse client/patient records, and state confidentiality laws and regulations. All such policies and procedures regarding problem gambling client/patients shall be in accordance with HIPAA and Iowa Code chapter 228.

g. Confidentiality of alcohol and drug abuse client/patient records. The confidentiality of alcohol and drug abuse client/patient records maintained by a program is protected by HIPAA and the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, effective June 9, 1987, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse client/patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse client/patient records.

h. Confidentiality of problem gambling client/patient records. The confidentiality of problem gambling client/patient records maintained by a program is protected by HIPAA and Iowa Code chapter 228.

i. The provision of treatment to a client/patient through any electronic means, including the Internet, telephone, or the Iowa communications network or any fiberoptic media, regardless of the location of the licensee, shall constitute the practice of treatment in the state of Iowa and shall be subject to regulation in accordance with Iowa Code chapter 125 and 2009 Iowa Code Supplement section 135.150 and these rules. A licensee who provides services via electronic media shall inform the client/patient of the limitations and risks associated with such services and shall document in the client/patient case record that such notice has been provided.

j. Confidentiality and transfer of records. Upon receipt of a properly executed written release of information signed by the client/patient, the program shall release client/patient records in a timely manner. A program shall not refuse to transfer or release client/patient records related to

continuation of care solely because payment has not been received. A program may refuse to release client/patient records which are unrelated to continuation of care if payment has not been received. A program may refuse to file the reporting form required by 641—subrule 157.3(1), “Notice Iowa Code 321J—Confidential Medical Record,” reporting screening, evaluation, and treatment completion, if payment has not been received for such services.

155.21(11) Placement screening, admission, assessment and evaluation.

a. The program shall conduct an initial assessment for substance abuse client/patients which shall include evaluation of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised, or other national or recognized criteria approved by the department upon granting a variance by the director in accordance with 641—Chapter 178 for determining the eligibility of individuals for placement and admission. The program shall utilize a recognized diagnostic test/tool to determine substance abuse or dependence as defined in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition).

b. The program shall conduct an initial assessment for problem gambling client/patients that shall utilize a recognized diagnostic test/tool to determine pathological gambling as defined in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). The client/patient is a problem gambler if the client/patient meets any of the diagnostic criteria for pathological gambling.

c. The program shall have written policies and procedures governing a uniform assessment process that defines:

- (1) The types of information to be gathered on all individuals upon admission;
- (2) Procedures to be followed when accepting referrals from outside agencies or organizations;
- (3) The types of records to be kept on all individuals applying for services.

d. Following admission, the comprehensive assessment (psychosocial history) shall be an analysis and synthesis of the client/patient’s status and shall address the client/patient’s strengths and needs, which may be documented in the comprehensive assessment or in the treatment plan, and areas of clinical concern. Sufficient information shall be collected so that a comprehensive treatment plan can be developed. The comprehensive treatment plan shall be developed within the period of time between admission and the first review date specified for that particular level of care within the management of care review process, or within 30 days for problem gambling client/patients.

e. At the time of admission, documentation shall be made that the individual has been informed of:

- (1) General nature and goals of the program;
- (2) Rules governing client/patient conduct and infractions that can lead to disciplinary action or discharge from the program;
- (3) In a nonresidential program, the hours during which services are available;
- (4) Treatment costs to be borne by the client/patient, if any;
- (5) Client/patient’s rights and responsibilities;
- (6) Confidentiality laws, rules and regulations;
- (7) HIV/AIDS information; and
- (8) Safety and emergency procedures for residential, halfway house, inpatient and treatment services with housing.

f. The results of the screening and admission process shall be clearly explained to the client/patient and to the client/patient’s family when appropriate. This shall be documented in the client/patient record.

155.21(12) Treatment plans. Based upon the initial assessment, an individualized written treatment plan shall be developed and recorded in the client/patient case record. The program shall have written policies and procedures governing a uniform process for treatment planning.

a. A treatment plan shall be developed as soon after the client/patient’s admission as is clinically feasible and within the period of time between admission and the next review date specified for that particular level of care within the management of care review process.

b. The individualized treatment plan shall minimally contain:

- (1) A clear and concise statement of the client/patient’s current strengths and needs, which may be documented in the treatment plan or in the comprehensive assessment;

(2) Clear and concise statements of the short- and long-term goals the client/patient will be attempting to achieve;

(3) Type and frequency of therapeutic activities in which the client/patient will be participating;

(4) The staff person(s) to be responsible for the client/patient's treatment; and

(5) Treatment plans shall be culturally and environmentally specific so as to meet the needs of the client/patient. Treatment plans shall be written in a manner readily understandable to the client/patient, with assistance if necessary.

c. Treatment plans shall be developed in partnership with the client/patient and shall be reviewed by the primary counselor and the client/patient as often as necessary and in accordance with the time frames specified within the management of care review process.

d. The reviews shall consist of: a reassessment of the client/patient's current status in conjunction with the continued stay review criteria, accomplishments and needs, and a redefining of treatment goals when appropriate. The date of the review, as well as any changes, shall be recorded in the record.

e. The use of abstract terms, technical jargon, or slang should be avoided in the treatment plan. The program should provide the client/patient with copies of all treatment plans upon request.

155.21(13) Progress notes. A client/patient's progress and current status in meeting the goals set in the treatment plan shall be recorded in the client/patient case record. Information will be noted following each individual counseling session and a summary of group counseling services shall be documented at least weekly.

a. Entries shall be filed in chronological order and shall include the date services were provided or observations made, the date the entry was made, and the signature or initials and staff title of the individual rendering the services. All progress notes shall be legibly entered into the client/patient case record in permanent pen, by typewriter, or by computer. In those instances where records are maintained electronically, a staff identification code number authorizing access shall be accepted in lieu of a signature.

b. All entries that involve subjective interpretations of a client/patient's progress should be supplemented with a description of the actual behavioral observations which were the basis for the interpretation.

c. The use of abstract terms, technical jargon, or slang should be avoided in progress notes.

d. The program shall develop a uniform progress note format to be used by all clinical staff.

155.21(14) Client/patient case record contents. There shall be a case record for each client/patient that contains:

a. Results of all examinations, tests, and screening and admissions information;

b. Reports from referring sources;

c. Treatment plans;

d. Continued stay and discharge reviews;

e. Medication records, which shall allow for the monitoring of all medications administered and self-administered and the detection of adverse drug reactions. All medication orders in the client/patient case records shall define at least the name of the medication, dose, route of administration, frequency of administration, the name of the physician who prescribed the medication, and the name of the person administering or dispensing the medication;

f. Reports from outside resources shall be dated and include the name of the resource;

g. Multidisciplinary case conference and consultation notes, including the date of the conference or consultation, recommendations made, actions taken, and individuals involved;

h. Correspondence related to the client/patient, including all letters and dated notations of telephone conversations relevant to the client/patient's treatment;

i. Treatment consent forms, if applicable;

j. Information release forms;

k. Progress notes;

l. Records of services provided;

m. Discharge summaries of services provided shall be completed within 30 days of discharge and shall be sufficiently detailed to identify the types of services the client/patient has received and action

taken to address specific problems identified. General terms such as “counseling” or “activities” shall be avoided in describing services;

- n.* Management information system or other appropriate data forms; and
- o.* Incident reports.
- p.* Records of financial counseling services for problem gambling client/patients. The treatment program shall offer financial counseling services to problem gambling client/patients. Financial counseling services shall be provided in-house or through consultation. If the treatment program determines that the problem gambling client/patient has financial problems, then financial counseling services shall include assisting the client/patient in preparing a budget and discussing financial debt options, including restitution and bankruptcy.

155.21(15) Drug screening. All programs serving client/patients who are receiving treatment for use or abuse of a controlled substance shall establish policies and procedures, if applicable, for the collection of urine specimens and utilization of urinalysis results.

a. Urine specimens obtained from client/patients shall be collected under direct supervision and analyzed as indicated by the program, or the program shall have a policy in place to reduce the client/patient’s ability to skew the test.

b. Any laboratory used by the program for urine testing and analysis shall comply, if applicable, with all federal and state proficiency testing programs.

c. Any program conducting on-site urine testing shall comply with the Clinical Laboratory Improvement Act regulations.

d. Client/patient records shall reflect the manner in which urine test results are utilized in treatment.

e. For programs with a urinalysis service, policies shall be developed concerning measures to be employed when urine specimens of client/patients are found to contain substances.

155.21(16) Medical services. The treatment program shall have policies and procedures developed in conjunction with a physician to examine and evaluate client/patients/concerned persons seeking or undergoing treatment or rehabilitation.

a. Individuals who enter an inpatient, residential, halfway house, chemotherapy or emergency care facility (ASAM Levels III.1, III.3, III.5, III.7 and IV) shall undergo a medical history and physical examination. Laboratory examinations may be performed as deemed necessary by the physician. The medical history, physical examination, and necessary laboratory examinations shall be performed as soon as possible, however minimally, as follows:

(1) Inpatient medically managed and medically monitored residential treatment services (ASAM Levels IV and III.7) within 24 hours of admission;

(2) Primary residential and extended residential treatment (Levels III.5 and III.3) within 7 calendar days of admission; and

(3) Halfway house services (Level III.1) within 21 calendar days of admission.

b. For individuals who enter a Level I or Level II service, a medical history shall be obtained upon admission.

c. A program may accept medical history and physical examination results from referral sources if the medical history and examination were completed no more than 90 days prior to admission.

d. All client/patients admitted to residential, inpatient or halfway house services and high-risk outpatient client/patients shall have a tuberculosis skin test administered and read within 5 days of admission. If the client/patient has documentation of a negative tuberculosis skin test within the previous 90 days, the tuberculosis test may be accepted if the client/patient does not show any symptoms. If the client/patient has unexplained symptoms or a history of positive tuberculosis skin tests, the physician shall determine what tests are needed.

155.21(17) Emergency medical services. The program shall ensure, by affiliation agreement, or contract, that emergency medical services at a general hospital are available on a 24-hour basis.

a. The program will maintain emergency medical service coverage on a 24-hour, seven days a week, basis.

b. The program shall ensure that all community service providers, medical facilities, law enforcement agencies, and other appropriate personnel are informed of the 24-hour emergency services and treatment available.

155.21(18) Medication control. Policies and procedures shall be developed to ensure that prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations. The written policies and procedures shall include, but not be limited to, the following:

a. Authorized personnel who administer medications shall be qualified, and an updated list of such personnel shall be maintained. Only the following are designated by 657—8.32(124,155A) as qualified individuals to whom a physician can delegate the administration of controlled substances:

(1) Persons who have successfully completed a medication administration course reviewed by the board of pharmacy examiners.

(2) Advanced emergency medical technicians and paramedics.

(3) Licensed physician assistants.

(4) Licensed pharmacists.

(5) Nurse, intern or other qualified individual delegated the responsibility to administer a prescription drug by a practitioner, licensed by the appropriate state board, to administer drugs to patients, in accordance with Iowa Code section 155A.4(2)“c.”

b. Medications shall be administered only in accordance with the instructions of the attending physician. The type and amount of the medication, the time and date, and the staff member administering the medication shall be documented in the client/patient’s record.

c. Self-administration of prescription medication shall be observed by a staff member who has been oriented to the program’s policies and procedures on self-administration. Self-administration of prescription medications shall be permitted only when the client/patient’s medication is clearly labeled. There shall be written policies and procedures relative to self-administration of prescription medications by client/patients and only when:

(1) Medications are prescribed by a physician.

(2) The physician agrees that the client/patient can self-administer the drug.

(3) What is taken, how, and when, are documented in the record of the client/patient.

d. Drugs/medications shall be prescribed by a physician or other practitioner authorized to prescribe under Iowa law.

e. Prescription drugs shall not be administered or self-administered to a client/patient without a written order signed by a physician or other practitioner authorized to prescribe under Iowa law. All prescribed medications shall be clearly labeled indicating the client/patient’s full name, physician’s name, prescription number, name and strength of the medication, dosage, directions for use, date of issue; and name, address and telephone number of the pharmacy or physician issuing the medication. Medications shall be packaged and labeled according to state and federal guidelines.

f. If the medications the client/patient brings to the program are not to be used, they shall be packaged, sealed and stored. The sealed packages of medications shall be returned to the client/patient, family or significant others at the time of discharge.

g. Accountability and control of medications.

(1) There shall be a specific routine for medication administration, indicating dose schedules and standardization of abbreviations.

(2) There shall be specific methods for control and accountability of medication products throughout the program.

(3) The staff member in charge of medications shall provide for monthly inspection of all storage units.

(4) Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal.

(5) Unused prescription drugs prescribed for residents who have left the facility without their medication shall be destroyed by the person in charge with a witness and notation made on the resident’s record. When a resident is discharged or leaves the facility, medications currently being administered

shall be sent, in the original container, with the resident or with a responsible agent, and with the approval of the physician.

h. Medication storage shall be maintained in accordance with the security requirements of federal, state and local laws.

(1) All medication shall be maintained in locked storage. Controlled substances shall be maintained in a locked box within the locked cabinet.

(2) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items.

(3) Disinfectants and medication for external use shall be stored separately from internal and injectable medications.

(4) The medication for each client/patient shall be stored in the original containers.

(5) All potent poisonous or caustic medication shall be plainly labeled, stored separately from other medication in a specific well-illuminated cabinet, closet, or storeroom, and made accessible only to authorized persons.

i. Dispensed from a licensed pharmacy. Medication provided to a client/patient shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Code of Iowa, or from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

j. Use of medications. Prescription medications prescribed for one resident may not be administered to or allowed in the possession of another resident.

k. Patient reaction. Any unusual client/patient reaction to a medication shall be documented in the client/patient record and reported to the attending physician immediately.

l. Dilution or reconstitution of medication. Dilution or reconstitution and labeling of medication shall be done only by a licensed pharmacist.

155.21(19) *Management of care.* The program shall ensure appropriate level of care utilization by implementing and maintaining the written placement screening, continuing service, and discharge criteria process developed by the department.

a. The program shall also address underutilization, overutilization, and the effective use of levels of care available.

b. The time frames for management of care activities minimally shall be implemented within 30 days for Levels I and III.1; within 7 days for Levels II.1, II.5, III.3 and III.5; and daily for Levels III.7 and IV.

c. The discharge planning process shall begin at admission and shall include a determination of the client/patient's continued need for treatment services and development of a plan to address ongoing client/patient needs posttreatment. Discharge planning may or may not include a document identified as a discharge plan.

155.21(20) *Quality improvement.* The program shall have an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of client/patient care, pursue opportunities to improve client/patient care, and resolve identified problems. Quality improvement efforts shall be facilitywide in scope and include review of clinical and professional services.

a. There shall be a written plan for a quality improvement program that describes the objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities.

b. The program shall establish written policies and procedures to both describe and document the quality improvement of the program's monitoring and evaluation activities. The policies and procedures shall ensure that:

(1) Information is collected or screened by a designated individual, individuals, or committee. Quality improvement activities may be contracted through all outside resources;

(2) Objective criteria shall be utilized in the development and application of criteria relating to the care or service it provides; and

(3) Objective criteria shall be utilized in the evaluation of the information collected in order to identify important problems in, or opportunities to improve, client/patient care and clinical performance.

c. The program shall document that the quality of client/patient care is improved and identified problems are resolved through actions taken as appropriate by the program's administrative and supervisory staffs and through professional staff functions.

d. Necessary information shall be communicated among program components, modalities, or services when problems or opportunities to improve client/patient care involve more than one program component or service.

e. The program shall ensure that the status of identified problems is tracked to ensure improvement or resolution.

f. Information from program components or services and the findings of discrete quality improvement activities are used to detect trends, patterns of performance, or potential problems that affect more than one program component or service.

g. The objectives, scope, organization, and effectiveness of the quality improvement program are evaluated at least annually and revised as necessary.

155.21(21) *Building construction and safety.* All buildings in which client/patients receive screenings, evaluations, assessments or treatment shall be designed, constructed, equipped, and maintained in a manner that provides for the physical safety of client/patients, personnel, and visitors.

a. If required by local jurisdiction, all programs shall maintain a certification of occupancy.

b. During all phases of construction or alterations of buildings, the level of life safety shall not be diminished in any occupied area. The construction shall be in compliance with all applicable federal, state, and local codes.

c. New construction shall comply with Iowa Code chapter 104A and all applicable federal and local codes and provide for safe and convenient use by disabled individuals.

d. All programs shall have written policies and procedures to provide a safe environment for client/patients, personnel, and visitors and to monitor that environment. The program shall document implementation of the procedures. The written policies and procedures shall include, but not be limited to, the following:

(1) The process for the identification, development, implementation, and review of safety policies and procedures for all departments or services.

(2) The promotion and maintenance of an ongoing, facilitywide hazard surveillance program to detect and report all safety hazards related to client/patients, visitors, and personnel.

(3) The process by which the staff is to dispose of biohazardous waste within the clinical service areas.

(4) All program areas.

1. Stairways, halls, and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

2. Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

3. For juvenile facilities, fuse boxes shall be under lock and key or six feet above the floor.

4. Facilities shall have written procedures for the handling and storage of hazardous materials.

5. Facilities shall have policies and procedures for weapons removal.

6. Swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

7. Facilities shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the program and accessible to the client/patient.

155.21(22) *Outpatient facility.* The outpatient facility shall be safe, clean, well ventilated, properly heated, free from vermin and rodents and in good repair.

a. The facility shall be appropriate for providing services available from the program and for protecting confidentiality.

b. Furniture shall be in good repair.

c. There shall be a written plan outlining procedures to be followed in the event of fire or tornado. These plans shall be conspicuously displayed at the facility.

155.21(23) Therapeutic environment. All programs shall establish an environment that enhances the positive self-image of client/patients and preserves their human dignity. The grounds of the program shall have adequate space for the program to carry out its stated goals. When client/patient needs or program goals involve outdoor activities, these activities and programs shall be appropriate to the ages and clinical needs of the client/patient.

a. All services shall be accessible to people with disabilities or the program shall have written policies and procedures that describe how people with disabilities can attain access to the facility for necessary services. All programs shall comply with the Americans with Disabilities Act.

b. The waiting or reception areas shall be of adequate size, have appropriate furniture and be located so as to ensure confidentiality of client/patients in session or receiving services.

c. Program staff shall be available in waiting or reception areas so as to address the needs of the client/patients and visitors.

d. The program shall have written policies and procedures regarding chemical substances in the facility.

e. Smoking shall be prohibited within any facilities or any portion of a facility used for outpatient drug and alcohol treatment services and programs. Smoking shall be prohibited, except in designated areas within facilities or portions of facilities used for inpatient and residential drug and alcohol treatment services.

f. A program or person shall not sell, give, or otherwise supply any tobacco, tobacco products, or cigarettes to any person under 18 years of age, and a person under 18 years of age shall not smoke, use, purchase, or attempt to purchase, any tobacco, tobacco products, or cigarettes.

g. There shall be written policies and procedures to address the following:

(1) There shall be a policy to inform client/patients of their legal and human rights at the time of admission;

(2) Client/patient communication, opinions, or grievances, with a mechanism for redress;

(3) Prohibition of sexual harassment; and

(4) Client/patient rights to privacy.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.22(125,135) Inpatient, residential, and halfway house safety. Specific safety standards for inpatient, residential and halfway house safety.

155.22(1) Health and fire safety inspections. Inpatient, residential and halfway house substance abuse treatment facilities shall comply with appropriate department of inspections and appeals rules, state fire marshal's rules and fire ordinances, and appropriate local health, fire, occupancy code, and safety regulations. The program shall maintain documentation of such compliance.

a. Inpatient, residential and halfway house substance abuse treatment facilities required to be licensed by the department of public health shall comply with standards for food service sanitation in accordance with rules promulgated by the department of inspections and appeals pursuant to 481—Chapter 32 of the Iowa Administrative Code and Iowa Code chapter 137B.

b. Food service operations in substance abuse inpatient, residential, and halfway house treatment facilities shall be inspected on an annual basis by the department of inspections and appeals or appropriate local boards of health having agreements with the department of inspections and appeals to conduct such inspections.

c. The use of door locks or closed sections shall be approved by the fire marshal, professional staff and governing body.

155.22(2) Emergency preparedness. The inpatient, residential and halfway house programs shall have an emergency preparedness program designed to provide for the effective utilization of available resources so that client/patient care can be continued during a disaster.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.23(125,135) Specific standards for inpatient, residential, and halfway house service. An inpatient, residential, and halfway house service shall be designed to provide comprehensive diagnostic, treatment and rehabilitation services in a 24-hour therapeutic setting.

155.23(1) Hours of operation. An inpatient, residential, and halfway house service shall operate seven days per week, 24 hours a day.

155.23(2) Meals. Inpatient and residential programs shall provide a minimum of three meals per day to each client/patient enrolled in the program. Inpatient, residential, and other programs where client/patients are not present during mealtime shall make provisions to make available the necessary meals. Menus shall be prepared in consultation with a dietitian. If client/patients are allowed to prepare meals, the program shall document conformity with all commonly accepted policies and procedures of state health regulations and food hygiene.

155.23(3) Consultation with counsel. An inpatient, residential, and halfway house program shall have policies and procedures which will ensure that all client/patients in a facility have opportunity for and access to consultation with legal counsel at any reasonable time.

155.23(4) Visitation with family and friends. An inpatient, residential, and halfway house program shall have policies and procedures which will ensure opportunities for continuing contact with family and friends. If such visiting opportunities are clinically contraindicated, they shall be approved on an individual basis by the treatment supervisor and subject to review by the executive director. The justification for restrictions shall be documented in the client/patient record. If clinical indications require restrictions on visitation, such restrictions shall be evaluated for continuing therapeutic effectiveness every seven days by the treatment supervisor and primary counselor.

The program shall establish visiting hours which shall be conspicuously displayed at the facility and in such a manner to be visible to those entering the facility.

155.23(5) Telephone use. An inpatient, residential, and halfway house program shall have policies and procedures which allow client/patients to conduct private telephone conversations with family and friends at the facility. If such are clinically contraindicated, they shall be approved on an individual basis by the treatment supervisor and subject to review by the executive director. The justification for restrictions shall be documented in the client/patient record. If clinical indications require restrictions, such shall be evaluated for continuing therapeutic effectiveness every seven days by the treatment supervisor and primary counselor. Access to the telephone shall be available during reasonable hours as defined by the program in written policies and procedures except for emergency calls, which may be received at the time of the call, or made when necessary.

155.23(6) Written communication. An inpatient, residential, and halfway house program shall have policies and procedures which ensure that neither mail nor other communications to or from a client/patient in a facility is intercepted, read, or censored.

155.23(7) Facility. An inpatient, residential, and halfway house facility shall be safe, clean, well-ventilated, properly heated, in good repair, and free from vermin to ensure the well-being of residents.

a. Client/patient bedrooms shall include:

- (1) A sturdily constructed bed;
- (2) A clean mattress protected with a clean mattress pad;
- (3) A designated space for personal possessions and for hanging clothing in proximity to the sleeping area; and
- (4) Windows in bedrooms shall have curtains or window blinds.

b. Sleeping areas shall include:

- (1) Doors for privacy;
- (2) Partitioning or placement of furniture to provide privacy for all client/patients;
- (3) The number of client/patients in a room shall be appropriate to the goals of the facility and to the ages, developmental levels, and clinical needs of the client/patients;
- (4) Client/patients will be allowed to keep and display personal belongings and add personal touches to the decoration of their rooms in accordance with program policy;

(5) Staff shall respect the client/patient's right to privacy by knocking on the door of the client/patient's room before entering.

c. Clean linen, towels and washcloths shall be available minimally on a weekly basis and more often as needed.

d. Bathrooms shall provide residents with facilities necessary for personal hygiene and personal privacy, including:

(1) A safe supply of hot and cold running water which is potable;

(2) Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap;

(3) Natural or mechanical ventilation capable of removing odors;

(4) Tubs or showers shall have slip-proof surfaces;

(5) Partitions with doors which provide privacy if a bathroom has multiple toilet stools;

(6) Toilets, wash basins, and other plumbing or sanitary facilities shall at all times be maintained in good operating condition; and

(7) The ratio of bathroom facilities to residents shall be one tub or shower head per 12 residents, one wash basin per 12 residents and one toilet per 8 residents.

(8) If the facility is coeducational, the program shall designate and so identify separate bathrooms for male and female client/patients.

e. There shall be a written plan outlining procedures to be followed in the event of fire or tornado. These plans shall be conspicuously displayed on each floor or dormitory area that client/patients, residents, or visitors occupy at the facility and shall be explained to all inpatient, residential, and halfway house client/patients as a part of their orientation to the program. Fire drills shall be conducted at least monthly and tornado drills conducted during the tornado season from April through October.

f. Written reports of annual inspections by state or local fire safety officials shall be maintained with records of corrective action taken by the program on recommendations articulated in such reports.

g. Smoking shall not be permitted in bedrooms.

h. Every facility shall have an adequate water supply from an approved source. A municipal water system shall be considered as meeting this requirement. Private water sources shall be tested annually.

i. The facility shall allow for the following:

(1) Areas in which a client/patient may be alone when appropriate; and

(2) Areas for private conversations with others.

j. Articles of grooming and personal hygiene that are appropriate to the client/patient's age, developmental level, and clinical state shall be readily available in a space reserved near the client/patient's sleeping area. If clinically indicated as determined by the treatment supervisor, a client/patient's personal articles may be kept under lock and key by staff. If access to potentially dangerous grooming aids or other personal articles is contraindicated for clinical reasons, a member of the professional staff shall explain to the client/patient the conditions under which the articles may be used; and the clinical rationale for these conditions shall be documented in the client/patient case record.

k. Housekeeping. If client/patients take responsibility for maintaining their own living quarters and for day-to-day housekeeping activities of the program, these responsibilities shall be clearly defined in writing and be a part of the client/patient orientation program. Staff assistance and equipment shall be provided as needed.

l. Clothing. Client/patients shall be allowed to wear their own clothing in accordance with program rules. If clothing is provided by programs, it shall be suited to the climate and appropriate. In addition, a laundry room shall be accessible so client/patients may wash their clothing.

m. Noise-producing equipment. The program shall ensure that the use and location of noise-producing equipment and appliances, such as television sets, radios, and CD players do not interfere with clinical and therapeutic activities.

n. Recreation and outdoor activities. The program shall provide recreation and outdoor activities, unless contraindicated for therapeutic reasons.

155.23(8) Religion-culture. The inpatient, residential, and halfway house program shall have a written description of its religious orientation, particular religious practices that are observed, and any

religious restrictions. This description shall be provided to the client/patients, parent(s) or guardian, and the placing agency at the time of admission in compliance with HIPAA and DHHS, 42 CFR Part 2, regulations on Confidentiality of Alcohol and Drug Abuse Patient Records. This information shall also be available to adults during orientation. The client/patient shall have the opportunity to participate in religious activities and services in accordance with the client/patient's own faith or that of a minor client/patient's parent(s) or guardian. The facility shall, when necessary and reasonable, arrange transportation for religious activities.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.24(125,135) Specific standards for inpatient, residential, and halfway house services for juveniles. An inpatient, residential, and halfway house program that houses one or more juveniles under the age of 18 must also comply with the following standards.

155.24(1) *Personal possessions.* The inpatient, residential, and halfway house program shall allow a child to bring personal belongings. However, the inpatient, residential, and halfway house program shall, as necessary, limit or supervise the use of these items. In addition, the program shall ensure that each child has adequate, clean, well-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being. The clothes should be appropriate to age, sex and individual needs.

155.24(2) *Family involvement.* There shall be written policies and procedures for family involvement that shall encourage continued involvement of the family.

155.24(3) *Children's money.* Money earned or received as a gift or as an allowance by a child in care shall be deemed to be that child's personal property. The program shall have a written policy on the child's use of funds. The program shall maintain a separate accounting system for children's money.

155.24(4) *Discipline.* The inpatient, residential, and halfway house program shall have written policies and procedures regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep.

a. The program shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated, in writing, to all staff of the facility.

b. Behavior expectations. The program shall make available to the child and the child's parents or guardian written policies regarding the following areas:

- (1) The general expectations of behavior including the program's rules and practices.
- (2) The range of reasonable consequences that may be used to deal with inappropriate behavior.

155.24(5) *Number of staff.* The program shall have 7 days per week, 24-hour per day coverage. The number and qualifications of the staff will vary depending on the needs of the children.

a. Inpatient, residential, halfway house programs, and community residential facilities as defined in 441—Chapter 114, shall have an on-call system operational 24 hours a day to provide supervisory consultation. The program shall have a written plan documenting this system. During prime programming time, there shall be at least a one-to-eight, staff-to-client/patient ratio.

b. Comprehensive residential facilities, as defined in 441—Chapter 115, shall have at least a one-to-five, staff-to-client/patient ratio during prime programming time. A staff person shall be in each living unit at all times when children are in residence, and there shall be a minimum of three nighttime checks between the hours of 12 midnight and 6 a.m. These checks shall be logged. Policies and procedures for nighttime checks shall be in writing.

c. The program's prime programming time shall be defined in writing.

155.24(6) *Illness, accident, death, or absence from the inpatient, residential, and halfway house program.* The program shall have written policies and procedures to notify the child's parent(s), guardian, and responsible agency of any serious illnesses, incidents involving serious bodily injury or absence, or circumstances causing removal of the child from the facility in compliance with HIPAA and DHHS, 42 CFR Part 2, regulations on Confidentiality of Alcohol and Drug Abuse Patient Records.

In the event of the death of a child, the program shall immediately notify the physician, the child's parent(s) or guardian, the placing agency, and the appropriate state authority.

155.24(7) Educational services. An educational program shall be available for each child in accordance with abilities and needs. The educational and teaching standards established by the state department of public instruction shall be met.

155.24(8) Needs of the juvenile. Program services and rules shall be designed to meet individual needs of the juvenile.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.25(125,135) Specific standards for assessment and evaluation programs.

155.25(1) Definitions. Rescinded IAB 6/2/10, effective 7/1/10.

155.25(2) Governing body. Each program shall have a formally designated governing body that is representative of the community being served, complies with Iowa Code chapter 504 and is the ultimate authority for the overall program operations. Persons in private practice as sole practitioners shall be exempt from this subrule except for the requirements to have malpractice and liability insurance.

a. The governing body shall develop and adopt written bylaws and policies that define the powers and duties of the governing body, its committees, advisory groups, and the executive director. These bylaws shall be reviewed and revised by the governing body as necessary.

b. The bylaws shall minimally specify the following:

- (1) The type of membership;
- (2) The term of appointment;
- (3) The frequency of meetings;
- (4) The attendance requirements; and
- (5) The quorum necessary to transact business.

c. Minutes of all meetings shall be kept and be available for review by the department and shall include, but not necessarily be limited to:

- (1) Date of the meeting;
- (2) Names of members attending;
- (3) Topics discussed; and
- (4) Decisions reached and actions taken.

d. The duties of the governing body shall include, but not necessarily be limited to, the following:

- (1) Appointment of a qualified executive director who shall have the responsibility and authority for the management of the program in accordance with the governing body's established policies;
- (2) Establish an effective control which will ensure that quality services are delivered;
- (3) Review and approve the program's annual budget; and
- (4) Approve all contracts.

e. The governing body shall develop and approve policies for the effective operation of the program.

f. The governing body shall be responsible for all funds, equipment, supplies and the facility in which the program operates. The governing body shall be responsible for the appropriateness and adequacy of services provided by the program.

g. The governing body shall at least annually prepare a report which will include, but not necessarily be limited to, the following items:

- (1) The name, address, occupation, and place of employment of each governing body member;
- (2) Any family relationship which a member of the governing body may have to a program staff member; and
- (3) Where applicable, the names and addresses of all owners or controlling parties whether they are individuals, partnerships, corporation body, or subdivision of other bodies, such as a public agency, or religious group, fraternity, or other philanthropic organization.

h. The governing body shall assume responsibility in seeing that the program has malpractice and liability insurance and a fidelity bond.

155.25(3) Executive director. This individual shall have primary responsibility for the overall program operations. The duties of the executive director shall be clearly defined by the governing authority, when applicable.

155.25(4) Clinical oversight. The program shall have appropriate clinical oversight to ensure quality of clinical services provided to client/patients. This may be provided in house or through a consultation agreement.

155.25(5) Staff development and training. There shall be written policies and procedures that establish staff development. Staff development shall include orientation for staff and opportunities for continuing job-related education. For corporations organized under Iowa Code chapter 496C and sole practitioners, documentation of continuing education to maintain a professional license or substance abuse certification as specified in 155.21(8) will meet the requirement of this subrule.

a. Evidence of professional education, substance abuse certification or licensing as specified in 155.21(8), or orientation which includes the following: psychosocial, medical, pharmacological, confidentiality, tuberculosis, community resources; screening, evaluation, HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) information/education; and the attitudes, values and lifestyles of racially diverse cultures, other cultures and special populations.

b. Staff development shall ensure that staff members are kept informed of new developments in the field of substance abuse screening, evaluation and placement.

155.25(6) Management information system. Programs receiving Medicaid or state funding and programs performing OWI evaluation in accordance with 641—Chapter 157 shall submit client/patient data to the Iowa Department of Public Health, Division of Behavioral Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075, in accordance with substance abuse reporting system procedures.

155.25(7) Procedures manual. All programs shall develop and maintain a procedures manual. This manual shall define the program's policies and procedures to reflect the program's activities. Revisions shall be entered with the date, name and title of the individual making the entries. This manual shall contain all of the required written policies, procedures, definitions, and all other documentation required by these standards in the following areas:

- a.* Legal authority and organization;
- b.* Personnel policies, except for sole practitioner;
- c.* Emergency medical services;
- d.* Staff development;
- e.* Maintenance of client/patient case records;
- f.* Confidentiality of client/patient records;
- g.* Clinical services, such as placement screening, evaluation and assessment; and
- h.* Relationship with other providers.

155.25(8) Fiscal management. The program shall ensure proper fiscal management.

a. The fiscal management system shall be maintained in accordance with generally accepted accounting principles, including internal controls to reasonably protect the agency assets.

b. The OWI evaluation fee schedule shall be made public, and the client/patient shall be informed of the fee schedule at the time of scheduling the evaluation.

c. There shall be an insurance program that provides for the protection of the physical and financial resources of the program which provides coverage for all people, buildings, and equipment. The insurance program shall be reviewed annually by the governing body.

155.25(9) Personnel. Written personnel policies and procedures shall be developed, except for the sole practitioner.

- a.* These policies and procedures shall address the following areas:
- (1) Recruitment, selection, and certification of staff members;
 - (2) Wage and salary administration;
 - (3) Promotions;
 - (4) Employee benefits;
 - (5) Working hours;

- (6) Vacation and sick leave;
- (7) Lines of authority;
- (8) Rules of conduct;
- (9) Disciplinary actions and termination of employees;
- (10) Methods for handling cases of inappropriate client/patient care;
- (11) Work performance appraisal;
- (12) Employee accidents and safety;
- (13) Employee grievances; and
- (14) Policy on staff persons suspected of using or abusing substances.

b. The written personnel policies and practices shall include an equal employment opportunity policy and an affirmative action plan for hiring members of protected classes that minimally comply with Iowa civil rights commission rules and any local ordinances.

c. There shall be written job descriptions that reflect the actual job situation.

d. The written personnel policies and practices shall include a mechanism for a written evaluation of personnel performance on at least an annual basis. There shall be evidence that this evaluation is reviewed with the employee and that the employee is given the opportunity to respond to this evaluation.

e. There shall be a personnel record kept on each staff member. These records shall contain as applicable:

- (1) Verification of training, experience, and all professional credentials relevant to the position;
- (2) Job performance evaluations;
- (3) Incident reports;
- (4) Disciplinary actions taken; and
- (5) Documentation of review and adherence to confidentiality laws and regulations. This review and agreement shall occur prior to assumption of duties.

f. There shall be written policies and procedures designed to ensure confidentiality of personnel records and a delineation of authorized personnel who have access to various types of personnel information.

155.25(10) Professional qualifications.

a. Personnel conducting screenings, placements, and assessments in accordance with this chapter shall meet the requirements of 155.21(8) "i."

b. The sole practitioner shall subscribe to a code of conduct found in professional certification or licensure as specified in 155.21(8).

155.25(11) Child abuse/dependent adult abuse/criminal history background check.

a. Written policies and procedures shall prohibit mistreatment, neglect, or abuse of children and dependent adults and shall specify reporting and enforcement procedures for the program. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Written policies and procedures on reporting alleged violations regarding substance abuse client/patients shall be in compliance with HIPAA and DHHS, 42 CFR Part 2, regulations on Confidentiality of Alcohol and Drug Abuse Patient Records. Any employee found to be in violation of Iowa Code sections 232.67 through 232.70, as substantiated by a department of human services' investigation shall be subject to the program's policies concerning dismissal.

b. For each employee working within a juvenile services area as set forth in Iowa Code section 125.14A or with dependent adults as set forth in Iowa Code chapter 235B, the following, at a minimum, shall be documented:

(1) Documentation of a criminal history background check with the Iowa division of criminal investigation on all new applicants for employment. The background check shall include asking whether the applicant has been convicted of a crime.

(2) A written, signed, and dated statement furnished by a new applicant for employment which discloses any substantiated reports of child abuse, neglect, or sexual abuse or dependent adult abuse.

(3) Documentation of a check after hiring on probationary or temporary status, but prior to permanently employing the individual, with the Iowa central registry for any substantiated reports of child abuse, neglect, or sexual abuse pursuant to Iowa Code section 125.14A or substantiated reports of

dependent adult abuse for all employees hired on or after July 1, 1994, pursuant to Iowa Code chapter 235B.

(4) A person who has a record of a criminal conviction or founded child abuse report or founded dependent adult abuse report shall not be employed, unless an evaluation of the crime or founded child abuse or founded dependent adult abuse has been made by the department of human services which concludes that the crime or founded child abuse or founded dependent adult abuse does not merit prohibition of employment. If a record of criminal conviction or founded child abuse or founded dependent adult abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310, Record Check Evaluation. In its evaluation, the department of human services shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, and the number of crimes or founded abuses committed by the person involved.

c. Each treatment staff member shall complete two hours of training relating to the identification and reporting of child abuse and dependent adult abuse within six months of initial employment, and at least two hours of additional training every five years thereafter.

155.25(12) Client/patient case record maintenance. There shall be written policies and procedures governing the compilation, storage and dissemination of individual client/patient case records.

a. These policies and procedures shall ensure that:

(1) The program exercises its responsibility for safeguarding and protecting the client/patient case record against loss, tampering, or unauthorized disclosure of information;

(2) Content and format of client/patient records are kept uniform; and

(3) Entries in the client/patient case record are signed and dated.

b. The program shall provide adequate physical facilities for the storage, processing, and handling of client/patient case records. These facilities shall include suitably locked, secured rooms or file cabinets.

c. Appropriate records shall be readily accessible to those staff members providing services directly to the client/patient and other individuals specifically authorized by program policy.

d. There shall be a written policy governing the disposal and maintenance of client/patient case records. Client/patient case records shall be maintained for not less than seven years from the date they are officially closed.

e. Each file cabinet or storage area containing client/patient case records shall be locked.

f. Policies shall be established that specify the conditions under which information on applicants or client/patients may be released and the procedures to be followed for releasing such information. All such policies and procedures shall be in accordance with HIPAA and the federal confidentiality regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," 42 CFR Part 2, effective June 9, 1987, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse client/patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse client/patient records, and state confidentiality laws and regulations.

g. Confidentiality of alcohol and drug abuse client/patient records. The confidentiality of alcohol and drug abuse client/patient records maintained by a program is protected by HIPAA and the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, effective June 9, 1987, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse client/patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse client/patient records.

h. Confidentiality and transfer of records. Upon receipt of a properly executed written release of information signed by the client/patient, the program shall release client/patient records in a timely manner. A program shall not refuse to transfer or release client/patient records related to continuation of care solely because payment has not been received. A program may refuse to release client/patient records which are unrelated to continuation of care if payment has not been received. A program may refuse to file the reporting form required by 641—subrule 157.3(1), "Notice Iowa Code 321J—Confidential Medical Record," reporting screening, evaluation, and treatment completion, if payment has not been received for such services.

155.25(13) Placement screening, evaluation and assessment. There shall be clearly stated written criteria for determining the eligibility of individuals for placement screening evaluation and assessment.

a. The program shall have written policies and procedures governing a uniform process that defines:

- (1) Procedures to be followed when accepting referrals from outside agencies or organizations;
- (2) The types of records to be kept on all individuals applying for services.

b. The program shall conduct a screening, which shall include evaluation of the ASAM-PPC-2 for determining the recommendation of individuals for placement into a level of care.

c. At the time of screening, documentation shall be made that the individual has been informed of:

- (1) Evaluation costs to be borne by the client/patient, if any;
- (2) Client/patient's rights and responsibilities; and
- (3) Confidentiality laws, rules and regulations.

d. Sufficient information shall be collected during the screening and evaluation process so that a recommendation can be made for placement into a level of care.

e. The results of the screening and evaluation process shall be clearly explained to the client/patient and to the client/patient's family when appropriate. This shall be documented in the client/patient record.

f. Programs conducting screenings and evaluations on persons convicted of operating a motor vehicle while intoxicated (OWI), Iowa Code section 321J.2, and persons whose driver's license or nonresident operating privileges are revoked under chapter 321J, shall do so in accord with and adhere to 641—Chapter 157.

155.25(14) Client/patient case record contents. There shall be a case record for each client/patient that contains:

a. Results of all examinations, tests, and screening and admissions information;

b. Reports from referring sources when applicable;

c. Reports from outside resources shall be dated and include the name of the resource;

d. Multidisciplinary case conference and consultation notes, including the date of the conference or consultation, recommendations made, actions taken, and individuals involved when applicable;

e. Correspondence related to the client/patient, including all letters and dated notations of telephone conversations relevant to the client/patient's treatment;

f. Information release forms;

g. Records of services provided; and

h. Management information system or other appropriate data forms.

155.25(15) Emergency medical services. The program shall ensure that emergency medical services are available through an affiliation agreement or contract or policy and procedure.

155.25(16) Management of care. The program shall ensure appropriate level of care utilization by implementing and maintaining the written placement screening.

155.25(17) Building construction and safety. All buildings in which client/patients receive treatment shall be designed, constructed, equipped, and maintained in a manner that provides for the physical safety of client/patients, personnel, and visitors.

a. All programs shall have written policies and procedures to provide a safe environment for client/patients, personnel and visitors. The program shall have written policies and procedures for the maintenance, supervision, and safe use of all its grounds and equipment.

b. Safety education shall include orientation of new employees to general facilitywide safety practices.

155.25(18) Outpatient facility. The outpatient facility shall be safe, clean, well-ventilated, properly heated and in good repair.

a. The facility shall be appropriate for providing services available from the program and for protecting client/patient confidentiality.

b. Furniture shall be clean and in good repair.

c. There shall be a written plan outlining procedures to be followed in the event of fire and tornado. This plan shall be conspicuously displayed at the facility.

d. All services shall be accessible to people with disabilities, or the program shall have written policies and procedures that describe how people with disabilities can gain access to the facility for necessary services.

e. The program shall ensure confidentiality of client/patients receiving services.

f. Smoking shall be prohibited.

155.25(19) *Client/patient rights.* The program shall maintain written policies and procedures that ensure that the legal and human rights of client/patients participating in the program are observed and protected.

a. There shall be procedures to inform all client/patients of their legal and human rights at the time of evaluation.

b. There shall be documentation of the implementation of these procedures.

c. There shall be written policies and procedures for:

- (1) Client/patient communications, e.g., opinions, recommendations;
- (2) Client/patient grievances, with a mechanism for redress;
- (3) Prohibition of sexual harassment; and
- (4) Implementation of the Americans with Disabilities Act.

d. There shall be procedures designed to protect client/patients' rights and privacy.

155.25(20) *Administrative and procedural standards.* The program shall comply with the following rules:

- a.* 641—155.2(125,135) Licensing.
- b.* 641—155.3(125,135) Type of licenses.
- c.* 641—155.4(125,135) Nonassignability.
- d.* 641—155.5(125,135) Application procedures.
- e.* 641—155.6(125,135) Application review.
- f.* 641—155.7(125,135) Inspection of licensees.
- g.* 641—155.8(125,135) Licenses—renewal.
- h.* 641—155.9(125,135) Corrective action plan.
- i.* 641—155.10(125,135) Grounds for denial of initial license.
- j.* 641—155.11(125,135) Suspension, revocation, or refusal to renew a license.
- k.* 641—155.12(125,135) Contested case hearing.
- l.* 641—155.13(125,135) Rehearing application.
- m.* 641—155.14(125,135) Judicial review.
- n.* 641—155.15(125,135) Reissuance or reinstatement.
- o.* 641—155.16(125,135) Complaints.
- p.* 641—155.17 Reserved.
- q.* 641—155.18(125,135) Deemed status.
- r.* 641—155.19(125,135) Funding.
- s.* 641—155.20(125,135) Inspection.

This rule is intended to implement Iowa Code section 125.13.

[ARC 8792B, IAB 6/2/10, effective 7/1/10]

641—155.26 to 155.34 Reserved.

641—155.35(125,135) Specific standards for opioid treatment programs. All programs that use methadone or other medications approved by the Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and the state of Iowa for use in the treatment of opioid addiction shall comply with this rule, HIPAA and Part II, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 42 CFR Part 8, Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction, effective May 18, 2001.

155.35(1) Definitions.

“Accredited opioid treatment program” means an opioid treatment program that is the subject of a current, valid accreditation from an accreditation body approved by the Substance Abuse and Mental Health Services Administration (SAMHSA).

“Certification” means the process by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the federal opioid treatment standards.

“Certification application” means the application filed by an opioid treatment program for purposes of obtaining certification from SAMHSA.

“Certified opioid treatment program” means an opioid treatment program that is the subject of a current, valid certification.

“Comprehensive maintenance treatment” means maintenance treatment provided in conjunction with a comprehensive range of appropriate medical and rehabilitative services.

“Detoxification treatment” means the dispensing of an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such a period.

“Interim maintenance treatment” means detoxification treatment for a period of more than 30 days but not in excess of 180 days.

“Maintenance treatment” means the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid addiction.

“Medical and rehabilitative services” means services such as medical evaluations, counseling, and rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement) that are intended to help patients in opioid treatment programs become or remain productive members of society.

“Medical director” means a physician who is licensed to practice medicine in accordance with Iowa Code chapter 148, 150, or 150A and who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director’s direct supervision.

“Medication unit” means a facility established as part of, but geographically separate from, an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer opioid agonist treatment medications or collect samples for drug testing or analysis.

“Opiate addiction” means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate-induced problems. Opiate dependence is characterized by an individual’s repeated self-administration of opiates that usually results in opiate tolerance, withdrawal symptoms, and compulsive drug-taking. Dependency may occur with or without the physiological symptoms of tolerance and withdrawal.

“Opioid agonist treatment medication” means any opioid agonist drug that is approved by the Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opiate addiction.

“Opioid drug” means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

“Opioid treatment” means the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. This term encompasses detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment.

“Opioid treatment program” or *“OTP”* means a program or practitioner engaged in opioid treatment or interim maintenance treatment.

“*Patient*” or “*client/patient*” means any individual who undergoes treatment in an opioid treatment program.

“*Program sponsor*” means the person responsible for the operation of the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

“*Short-term detoxification treatment*” means detoxification treatment for a period not in excess of 30 days.

“*State authority*” means the Iowa department of public health, division of behavioral health, which regulates the treatment of opiate addiction with opioid drugs.

“*Treatment plan*” means a plan that outlines for each patient attainable short-term treatment goals that are mutually acceptable to the patient and the opioid treatment program and that specifies the services to be provided and the frequency and schedule for their provision.

155.35(2) Required approvals. All opioid treatment programs shall be licensed or approved by the committee and shall maintain all other approvals required by the Drug Enforcement Administration, Substance Abuse and Mental Health Services Administration and the Iowa board of pharmacy in order to provide services.

155.35(3) Central registry system. To prevent simultaneous enrollment of a client/patient in more than one program, all opioid treatment programs shall participate in a central registry as established by the division.

Prior to admission of an applicant to an opioid treatment program, the program shall submit to the registry the applicant’s name, birth date, and date of intended admission, and any other information required for the clearance procedure. No person shall be admitted to a program who is found by the registry to be participating in another such program. All opioid treatment programs shall report all admissions, discharges, and transfers to the registry immediately. All information reported to the registry from the programs and all information reported to the programs from the registry shall be treated as confidential in accordance with HIPAA and “Confidentiality of Alcohol and Drug Abuse Patient Records” regulations, 42 CFR Part 2, effective June 9, 1987.

a. Definitions. For purposes of this subrule:

“*Central registry*” means the system through which the Iowa department of public health, division of behavioral health, obtains client/patient identifying information about individuals applying for maintenance or detoxification treatment for the purpose of preventing an individual’s concurrent enrollment in more than one such program.

“*Opioid treatment program*” means a detoxification or maintenance treatment program which is required to report client/patient identifying information to the central registry and which is located in the state.

b. Restrictions on disclosure. A program may disclose client/patient identifying information to a central registry for the purpose of preventing multiple enrollment of a client/patient only if:

- (1) The disclosure is made when:
 1. The client/patient is admitted for treatment; or
 2. The treatment is interrupted, resumed or terminated.
- (2) The disclosure is limited to:
 1. Client/patient identifying information; and
 2. Relevant dates of admission.
- (3) The program shall inform the client/patient of the required disclosure prior to admission.

c. Use of information limited to prevention of multiple enrollments. Any information disclosed to the central registry to prevent multiple enrollments may not be redisclosed by the registry or such information used for any other purpose than the prevention of multiple enrollments unless so authorized by court order in accordance with HIPAA and 42 CFR Part 2, effective June 9, 1987.

d. Permitted disclosure by the central registry to prevent a multiple enrollment. If a program petitions the central registry, and an identified client/patient is enrolled in another program, the registry may disclose:

(1) The name, address, and telephone number of the program in which the client/patient is currently enrolled to the inquiring program; and

(2) The name, address, and telephone number of the inquiring program to the program in which the client/patient is currently enrolled. The programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

155.35(4) Admission requirements.

a. Prior to or at the time of a client/patient's admission to an opioid treatment program, the program shall conduct a comprehensive assessment so as to determine appropriateness for admission.

b. The program shall verify, to the extent possible, the client/patient's name, address, and date of birth.

c. The program physician shall determine and document in the client/patient's record that the client/patient is physiologically dependent on narcotic substances and has been so dependent for at least one year prior to admission. A one-year history of addiction means that the client/patient was physiologically dependent on a narcotic at a time one year before admission to a program and was addicted for most of the year preceding admission.

(1) When physiological addiction cannot be clearly documented, the program physician or an appropriately trained staff member designated and supervised by the physician shall record in the client/patient's record the criteria used to determine the client/patient's current physiologic dependence and history of addiction. In the latter circumstance, the program physician shall review, date, and countersign the supervised staff member's evaluation to demonstrate the physician's agreement with the evaluation. The program physician shall make the final determination concerning a client/patient's physiologic dependence and history of addiction. The program physician also shall sign, date, and record a statement that the physician has reviewed all the documented evidence to support a one-year history of addiction and the current physiologic dependence and that in the physician's reasonable clinical judgment the client/patient fulfills the requirements for admission to maintenance treatment. Before the program administers any medication to the client/patient, the program physician shall complete and record the statement documenting addiction and current physiologic dependence.

(2) When a client/patient has voluntarily left an opioid treatment program in good standing and seeks readmission within two years of discharge, the program shall document the following information:

1. Prior opioid treatment of six months or more; and

2. The program physician shall enter in the client/patient's record that in the physician's medical judgment treatment is warranted.

d. The program shall collect a drug screening sample for analysis. Where dependence is substantially verified through other indicators, a negative drug screen will not necessarily preclude admission to the program.

e. Prior to admission, the program shall confirm with the central registry that the client/patient is not currently enrolled in another opioid treatment program.

f. If a potential client/patient has previously been enrolled in another program, the admitting program shall request from the previous program a copy of the client/patient's assessment data, treatment plan, and discharge summary including the type of or reason for discharge. All programs subject to these rules shall promptly respond to such a request upon receipt of a valid release of information.

g. A person under the age of 18 is required to have had two documented attempts at short-term detoxification or drug-free treatment to be eligible for maintenance treatment. A one-week waiting period is required after such a detoxification attempt, however, before an attempt is repeated. The program physician shall document in the client/patient's record that the client/patient continues to be, or is again, physiologically dependent on narcotic drugs.

h. Program staff shall ensure that a client/patient is voluntarily participating in the program, and the client/patient shall sign a Consent to Treatment Form.

i. Pregnant client/patients may be admitted to opioid treatment with the following provisions:

(1) Evidence of current physiological dependency is not needed if the program physician certifies the pregnancy and, in the physician's reasonable judgment, finds treatment to be justified. Documentation of all findings and justifications for admission shall be documented in the client/patient's record by the program physician prior to the initial dose of methadone.

(2) Pregnant client/patients shall be offered comprehensive prenatal care. If the program cannot provide prenatal services, the program shall assist the client/patient in obtaining such services and shall coordinate ongoing care with the collateral provider.

(3) The program physician shall document that the client/patient has been informed of the possible risks to the unborn child from the use of medication and the risks of continued use of illicit substances.

(4) Should a program have a waiting list for admission to the program, pregnant client/patients shall be given priority.

155.35(5) Placement, admission and assessment. The program shall have written criteria for considering an individual for placement and admission. In addition, the program shall maintain current procedures to ensure that patients are admitted to maintenance treatment by qualified staff who have determined by using accepted medical criteria such as those outlined in the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) that the person is currently addicted to an opioid drug.

a. The program shall have written policies and procedures governing a uniform process that defines:

- (1) The types of information to be gathered on all individuals upon admission;
- (2) Procedures to be followed when accepting referrals from outside agencies or organizations;
- (3) The types of records to be kept on all individuals applying for services.

b. The client/patient assessment (psychosocial history) shall be an analysis and synthesis of the client/patient's status, and shall address the client/patient's strengths, problems, and areas of clinical concern.

It shall be developed within the period of time between admission and the first review date specified for that particular level of care within the continued stay review process. This initial assessment upon admission to treatment services is an expansion of information on the six categories contained within the placement screening document.

c. When an individual refuses to divulge information or to follow the recommended course of treatment, this refusal shall be noted in the case record.

d. At the time of admission, documentation shall be made that the individual has been informed of:

- (1) General nature and goals of the program;
- (2) Rules governing client/patient conduct and infractions that can lead to disciplinary action or discharge from the program;
- (3) The hours during which the services are available;
- (4) Treatment costs, if any, to be borne by the client/patient;
- (5) Client/patient rights and responsibilities;
- (6) Confidentiality laws, rules and regulations; and
- (7) Information on preventing exposure to and transmission of human immunodeficiency virus.

e. Sufficient information shall be collected during the admission process so that the assessment process allows for the development of a complete assessment of the client/patient's status and a comprehensive plan of treatment can be developed.

f. The results of the screening and admission process shall be clearly explained to the client/patient, and to the client/patient's family when appropriate. This shall be documented in the client/patient record.

g. The program physician or designee, who is a qualified medical professional, shall complete a medical evaluation and a current psychological/mental status evaluation of the client/patient prior to the administration of the initial dose of medication. If the history and current psychological/mental status evaluation is completed by an individual other than the program physician, the program shall document in the client/patient's case record that this information was reviewed by the program physician prior to the initial dosage of medication. The medical evaluation shall include but not be limited to:

- (1) A complete medical history;
- (2) An assessment of the client/patient's current psychological and mental status;
- (3) A physical examination including examination for:
 1. Pulmonary, liver, or cardiac abnormalities;
 2. Infectious disease; and
 3. Dermatologic sequela of addiction.
- (4) Laboratory tests including:
 1. Serological test for syphilis; and
 2. Urine screening for drugs.
- (5) Intradermal PPD (tuberculosis skin test) and review of tetanus immunization status; and
- (6) When indicated, an EKG, chest X-ray, pap smear, pregnancy test, sickle cell screening, complete blood count and white cell differential, multiphasic chemistry profile, routine and microscopic urinalysis, or other tests indicated by the client/patient's condition.

155.35(6) Treatment plans. Based upon the initial assessment, an individualized written treatment plan shall be developed and recorded in the client/patient's case record.

a. A treatment plan shall be developed and shall delineate the client/patient's immediate needs and actions required to meet these needs.

b. The treatment plan shall be developed as soon after the client/patient's admission as is clinically feasible, but no later than 30 days following admission to an outpatient opioid maintenance treatment program.

c. The individualized treatment plan shall minimally contain:

- (1) A clear and concise statement of client/patient's current strengths and needs;
- (2) Clear and concise statements of the short- and long-term goals the client/patient will be attempting to achieve;
- (3) Type and frequency of therapeutic activities in which the client/patient will be participating;
- (4) The staff person(s) to be responsible for the client/patient's treatment; and
- (5) The specific criteria to be met for successful completion of treatment.

d. Treatment plans shall be developed in partnership with the client/patient. Comprehensive treatment plans shall be reviewed by the primary counselor and the client/patient as often as necessary, but no less than every 90 days during the first year and semiannually each subsequent year for opioid treatment modalities. Treatment plans shall be reviewed by the program physician on an annual basis.

e. The reviews shall consist of a reassessment of the client/patient's current status to include accomplishments and needs and a redefining of treatment goals when appropriate. The date of the review and any change, as well as the individuals involved in the review, shall also be recorded.

f. The use of abstract terms, jargon, or slang should be avoided in the treatment plan, and the plan should be written in a manner readily understandable to the average client/patient. The program shall provide the client/patient with copies of all treatment plans upon request.

g. Treatment plans shall be culturally and environmentally specific so as to meet the needs of the client/patient. Treatment plans shall be written in a manner readily understandable to the average person or with assistance available to illiterate, handicapped, or mentally impaired client/patients.

155.35(7) Progress notes. A client/patient's progress and current status in meeting the goals set in the treatment plan, as well as efforts by staff members to help the client/patient achieve these stated goals, shall be recorded in the client/patient's case record. Such information will be noted following each individual counseling session. Group therapy progress notes shall be recorded following each session or summarized at least weekly.

a. Entries shall be filed in chronological order and shall include the date services were provided or observations made, the date the entry was made, the signature or initials and staff title of the individual rendering the services. All progress notes shall be entered into the client/patient case record in permanent pen, typewriter, or by computer.

b. All entries that involve subjective interpretations of a client/patient's progress should be supplemented with a description of the actual behavioral observations which were the basis for the interpretation.

- c. The use of abstract terms, jargon, or slang should be avoided in progress notes.
- d. If a client/patient is receiving services from an outside resource, the program shall attempt to secure a written copy of status reports and other client/patient records from that resource.
- e. The program shall develop a uniform progress notes format to be used by all clinical staff.

155.35(8) *Rehabilitative services.* The program shall have policies and procedures on the minimum attendance for rehabilitative services relative to the client/patient's progress and length of involvement in treatment. The minimum frequency of rehabilitative services shall occur at the same frequency of on-site dosing for client/patients receiving more than two take-home dosages a week in the first year. The minimum frequency for rehabilitative services for client/patients receiving two or fewer take-home dosages shall be weekly. The program shall provide rehabilitative services that are appropriate for the client/patient based on needs identified during the assessment process. The program may provide rehabilitative services through collateral agreements with other service providers. A client/patient who does not comply with the program's rehabilitative service requirements shall be placed on a period of probation as defined by the program, or be required to immediately increase the frequency of clinic attendance for medication and rehabilitative services. If, during a period of probation, the client/patient continues to be in noncompliance with rehabilitation services, the program shall continue to increase the attendance requirement until daily attendance is obtained or the client/patient complies with rehabilitative services. This requirement shall not preclude the program's ability to determine that discharge of a client/patient is warranted for therapeutic reasons or program needs.

155.35(9) *Medication dispensing.*

a. The program physician shall determine the client/patient's initial and subsequent dose of medication and clinic dosing schedule and shall assume responsibility for the amount of the narcotic drug administered or dispensed and shall record, date, and sign in each client/patient's case record each change in the dosage schedule. The physician shall directly communicate orders to the pharmacy or registered or licensed personnel supervising medication dispensing. The program physician may communicate such orders verbally; however, orders shall be reduced in writing and countersigned within 72 hours by the program physician.

b. The initial dose of medication shall not exceed 30 milligrams, and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the client/patient's case record that 40 milligrams did not suppress opiate abstinence symptoms. A client/patient transferring into the program or on a guest-dosing status may receive an initial dosage of no more than the last daily dosage authorized by the former or primary program.

(1) Medication shall be administered by a professional authorized by law.

(2) No medication shall be administered unless the client/patient has completed admission procedures, unless the client/patient enters the program on a weekend and the central registry cannot be contacted. If, in the clinical judgment of the program physician, a client/patient is experiencing an emergency situation, the admission procedures may be completed on the following workday.

c. Administration.

(1) Take-home medication shall be labeled in accordance with state and federal law and have childproof caps.

(2) A dispensing log shall be kept in the dispensing area and in the client/patient case records which shall document the amount of medication dispensed and include the signature of the staff member authorized to dispense the medication. No dose shall be dispensed until the client/patient has been positively identified and the dosage amount is compared with the currently ordered and documented dosage level.

(3) Ingestion shall be observed and verified by the staff person authorized to dispense the medication.

(4) The program physician shall record, date, and sign in each client/patient's case record each change in the dosage schedule. Daily dosages of medications in excess of 100 milligrams shall be dispensed only with the approval of the program physician and shall be documented and justified in the client/patient's case record.

155.35(10) Take-home or unsupervised medication use.

a. Take-home medication may be given to client/patients who demonstrate a need for a more flexible schedule in order to enhance and continue rehabilitative progress. For client/patients receiving take-home medication, the program shall document the following requirements:

- (1) Absence of recent abuse of drugs (narcotic or nonnarcotic), including alcohol;
- (2) Regular attendance at the clinic;
- (3) Attendance at a licensed or approved treatment program for rehabilitative services (e.g., programs are considered approved when licensed or approved in accordance with Iowa Code chapter 125);
- (4) Absence of recent criminal activity;
- (5) Stable home environment and social relationships;
- (6) Active employment or participation in school, or similar responsible activities related to employment, education or vocation; and
- (7) Assurance that medication can be safely transported and stored by the client/patient for the client/patient's own use.

b. Prior to granting take-home privileges, the program physician shall document in the client/patient's case record that all the above criteria have been considered and that, in the physician's professional judgment, the risk of diversion or abuse is outweighed by the rehabilitative benefits to be derived.

c. If the client/patient meets the above criteria, the client/patient may receive take-home medication according to the following guidelines:

- (1) During the first 90 days of treatment, the take-home supply is limited to a single dose each week;
- (2) During the second 90 days of treatment, the take-home supply is limited to two doses per week;
- (3) In the remaining months of the first year, a patient may be given a maximum six-day supply of take-home medication;
- (4) After one year of continuous treatment, a patient may be given a maximum two-week supply of take-home medication;
- (5) After two years of continuous treatment, a patient may be given a maximum one-month supply of take-home medication; and
- (6) Take-home medication shall not be dispensed to patients in interim maintenance treatment or detoxification.

d. If a client/patient is unable to conform to the applicable mandatory schedule, a revised schedule may be permitted provided the program receives an exception to these rules from the division and SAMHSA, when applicable. A copy of the written exception shall be placed in the client/patient's case record. The division will consider exceptions only in unusual circumstances. When a program is applying for less frequent pickups for client/patients, approval will be based on considerations in addition to distance when another program exists within 25 miles of the client/patient's residence.

e. Should a patient receiving take-home medication provide a drug screen that is confirmed either positive for substances or negative for the prescribed medication, the program shall ensure that when test results are used, presumptive laboratory results are distinguished from results that are definitive.

(1) The program physician shall place the client/patient on three months' probation, as defined by the program, or increase the client/patient's frequency of clinic dosing after considering the client/patient's overall progress and length of involvement in the program.

(2) Should the client/patient provide a drug screen that is positive for substances or negative for medication during a period of probation, the program physician shall increase the client/patient's frequency of clinic attendance for dosage pickup for at least three months. If after the three-month period the client/patient meets the eligibility criteria, the client/patient may return to the previous take-home schedule.

f. Take-home or unsupervised dosages of medication in excess of 100 milligrams may be dispensed by the program physician when the need for those dosages is carefully reviewed and considered and justified in the client/patient's case record based on the physician's clinical judgment.

155.35(11) Drug testing. Each program shall establish policies and procedures for the collection of drug-screening specimens and utilization of results.

a. The program shall ensure that an initial drug-screening test or analysis is completed for each prospective client/patient and that at least eight additional random tests or analyses are performed on each client/patient during the first year in maintenance treatment and that at least quarterly random tests or analyses are performed on each client/patient in maintenance treatment for each subsequent year. When a sample is collected from each client/patient for such a test or analysis, it shall be done in a manner that minimizes opportunity for falsification. Each test or analysis shall be analyzed for opiates, methadone, amphetamines, cocaine, and barbiturates. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must be analyzed for any of those drugs as well. Any laboratory that performs the testing required under this rule shall be in compliance with all applicable federal proficiency testing and licensing standards and all applicable state standards.

b. The program shall ensure that test results are not used as the sole criterion to force a client/patient out of treatment but are used as a guide to change treatment approaches. The program shall also ensure that when test results are used, presumptive laboratory results are distinguished from results that are definitive.

155.35(12) Client/patient case records. The program shall have written policies and procedures governing the compilation, storage and dissemination of individual client/patient case records.

a. These policies and procedures shall ensure that:

(1) The program exercises its responsibility for safeguarding and protecting the client/patient case records against loss, tampering, or unauthorized disclosure of information;

(2) Content and format of client/patient case records are kept uniform; and

(3) Entries in the client/patient case record are signed and dated.

b. The program shall provide adequate physical facilities for the storage, processing, and handling of client/patient case records. These facilities shall include suitably locked, secured rooms or file cabinets.

c. Appropriate records shall be readily accessible to those staff members providing services directly to the client/patient and other individuals specifically authorized by program policy. Records should be kept in proximity to the area in which the client/patient normally receives services.

d. The program shall have a written policy governing the disposal and maintenance of client/patient case records. Client/patient case records shall be maintained for not less than seven years from the date they are officially closed.

e. Confidentiality of alcohol and drug abuse client/patient case records. The confidentiality of alcohol and drug abuse client/patient case records maintained by a program is protected by HIPAA and the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, effective June 9, 1987, which implement federal statutory provisions, 42 U.S.C. 290dd-3 applicable to alcohol abuse client/patient records, and 42 U.S.C. 290ee-3 applicable to drug abuse client/patient records. The program is precluded from identifying that a client/patient attends the program or disclosing any information identifying a client/patient as an alcohol or drug abuser unless:

(1) The client/patient consents in writing;

(2) The disclosure is allowed by a court order;

(3) The disclosure is made to medical personnel in a medical emergency; or

(4) The disclosure is required by law.

f. Confidentiality and transfer of records. Upon receipt of a properly executed written release of information signed by the client/patient, the program shall release client/patient records in a timely manner. A program shall not refuse to transfer or release client/patient records related to continuation of care solely because payment has not been received. A program may refuse to release client/patient records which are unrelated to continuation of care if payment has not been received. A program may refuse to file the reporting form required by 641—subrule 157.3(1), "Notice Iowa Code 321J—Confidential Medical Record," reporting screening, evaluation, and treatment completion, if payment has not been received for such services.

155.35(13) Diversion prevention plan.

a. The program shall develop a diversion identification and prevention plan that:

(1) Outlines methods by which the program shall detect possible diversion of take-home medication; and

(2) Actions to be taken when diversion is identified or suspected.

b. The program shall establish and implement proactive procedures to reduce the likelihood or possibility of diversion.

155.35(14) Quality improvement. The program shall have an ongoing quality improvement process designed to objectively and systematically monitor and evaluate the quality and appropriateness of client/patient care, pursue opportunities to improve client/patient care, and resolve identified problems. Quality improvement efforts shall be facilitywide in scope and include review of clinical and professional services.

a. The program shall have a written plan for a quality improvement process. The written plan shall describe the objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities.

b. The program shall establish written policies and procedures to describe and document the quality improvement process, including the monitoring and evaluation activities of the program. The policies and procedures shall ensure that:

(1) Information is collected or screened by a designated individual, individuals, or committee. Quality improvement activities may be contracted through all outside resources;

(2) Objective criteria are utilized in the development and application of criteria relating to the care or service the program provides; and

(3) Objective criteria are utilized in the evaluation of the information collected in order to identify important problems in, or opportunities to improve, client/patient care and clinical performance.

c. The program shall document that the quality of client/patient care is improved and identified problems are resolved through appropriate actions taken by the program's administrative and supervisory staff and through professional staff functions.

d. Necessary information shall be communicated among program components, modalities, or services when problems or opportunities to improve client/patient care involve more than one program component or service.

e. The program shall ensure that the status of identified problems is tracked to ensure improvement or resolution.

f. The program shall ensure that information from program components or services and the findings of discrete quality improvement activities are used to detect trends, patterns of performance, and potential problems that affect more than one program component or service.

g. The objectives, scope, organization, and effectiveness of the quality improvement process are evaluated at least annually and revised as necessary.

155.35(15) Interim maintenance treatment.

a. An approved program may offer interim maintenance treatment when, due to capacity, the program cannot place the client/patient in a program offering comprehensive services within 14 days of the client/patient's application for admission.

b. An approved program may provide interim maintenance treatment only if the program also provides comprehensive maintenance treatment to which interim maintenance treatment client/patients may be transferred.

c. Interim maintenance treatment program approval. Before a public or nonprofit private narcotic treatment program may provide interim maintenance treatment, the program must receive approval of both the U.S. Food and Drug Administration and the division of behavioral health and:

(1) The program director must certify that the program seeking such authorization is unable to place client/patients in a public or private nonprofit program within a reasonable geographic area within 14 days of the client/patient's application for admission; and

(2) That interim maintenance treatment will not reduce the capacity of the program's comprehensive maintenance treatment.

(3) Client/patients admitted to interim maintenance treatment shall be transferred to comprehensive maintenance treatment within 120 days of admission.

d. Minimum standards for interim maintenance treatment. The program may admit a client/patient who is eligible for comprehensive maintenance treatment to interim maintenance treatment if the client/patient cannot be placed in a public or private nonprofit comprehensive program within a reasonable geographic area and within 14 days of application for services. An initial drug screen, and at least two others, shall be taken from the client/patient during the maximum admission period of 120 days. A program shall establish and follow reasonable criteria for determining the transfer of client/patients to comprehensive maintenance treatment. These transfer criteria shall be in writing, available for inspection, and shall include at a minimum a preference for the transfer of pregnant client/patients. Interim maintenance shall be conducted in accordance with all applicable federal regulations and state rules. The program shall notify the division when a client/patient begins interim treatment; when a client/patient leaves interim treatment, and when a client/patient transfers to comprehensive maintenance treatment. Such notifications shall be documented by the program in the client/patient's case record. All requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the following exceptions:

- (1) The medication is required to be administered daily under observation;
- (2) Take-home medication is not allowed;
- (3) Initial and comprehensive treatment plans are not required;
- (4) A primary counselor is not required to be assigned to the client/patient; and
- (5) Interim maintenance cannot be provided for longer than 120 days in any 12-month period.

155.35(16) *Complaints, investigations, suspension and revocation.* The rules relating to complaints, investigations, suspension and revocation as outlined in 641—155.11(125,135) through 641—155.16(125,135) shall apply to opioid treatment programs.

155.35(17) *Deemed status.* The committee shall grant deemed status to programs accredited either by a recognized national or not-for-profit accreditation body when the committee determines that the accreditation is for the same services.

a. National accreditation bodies. The national accreditation bodies currently recognized as meeting committee criteria for possible deemed status are:

- (1) Joint Commission.
- (2) Council on Accreditation of Rehabilitation Facilities (CARF).
- (3) Council on Accreditation of Children and Family Services (COA).
- (4) American Osteopathic Association (AOA).

b. Credentials and expectations of accreditation bodies.

(1) The accreditation credentials of the bodies shall specify the types of organizations, programs, and services the bodies accredit and targeted population groups, if appropriate.

(2) Deemed status means that the committee and division shall recognize, in lieu of their own review, an outside body's review, assessment and accreditation of a hospital-based or freestanding community-based substance abuse program's operations, functioning, and services that correspond to those described in this chapter.

c. Responsibilities of programs granted deemed status.

(1) When a program receives accreditation and is then granted licensure through deemed status, the program shall continue to be responsible for meeting all requirements in accordance with this chapter and all applicable laws and regulations.

(2) If a program that is nationally accredited requests deemed status for services not covered by the national accreditation body's standards, but covered by this chapter, the licensing for those services shall be conducted by the division.

(3) Copies of the entire CARF, Joint Commission, COA or AOA behavioral health accreditation survey/inspection report and certificate of accreditation shall be submitted to the division with the application for deemed status provided by the division.

(4) The program shall submit to the division accreditation corrective plans or written conditions to accreditation.

(5) The program shall be currently accredited by a committee-approved national accreditation body for services that are outlined in this chapter.

(6) The program shall advise the division of any changes in the program's accreditation status, address, executive director/CEO, facility locations, or any other changes to the program/organization within 30 days of such changes.

(7) All survey reports for the hospital-based or freestanding community-based substance abuse treatment program from the accrediting or licensing body shall be sent to the division.

(8) For a program granted deemed status, the period of deemed status shall coincide with the period of time that program is awarded accreditation by the national accreditation body. However, under no circumstances shall it be longer than three years.

d. The committee and division shall retain the following responsibilities and rights when deemed status is granted to program/organizations:

(1) The division may conduct focused or general on-site follow-up visits as determined appropriate.

(2) The division shall investigate all complaints that are under the authority of this chapter and recommend and require corrective action or other sanctions in accordance with 641—155.16(125,135). All complaints, findings and required corrective action may be reported to the accreditation body.

(3) The committee shall review and act upon deemed status if necessary when complaints have been founded, when national accreditation bodies find instances of noncompliance with accreditation, when the accreditation status of the program expires without renewal, when the program's accreditation status is downgraded or withdrawn by the accreditation body, or when focused reviews find instances of noncompliance.

e. Continuation of deemed status. The program shall submit a copy of all CARF, Joint Commission, COA or AOA behavioral health accreditation survey reports to the division.

155.35(18) Personnel qualifications.

a. Personnel providing screening, evaluations, assessments or treatment in accordance with this chapter shall meet the requirements of 155.21(8) "i."

b. Personnel in opioid treatment programs shall subscribe to a code of conduct found in professional certification or licensure as specified in 155.21(8).

[ARC 8792B, IAB 6/2/10, effective 7/1/10; ARC 9534B, IAB 6/1/11, effective 7/6/11]

These rules are intended to implement Iowa Code sections 125.13, 125.21 and 135.150.

[Filed emergency 3/20/78—published 4/5/78, effective 3/20/78]

[Filed 6/9/78, Notice 5/3/78—published 6/28/78, effective 8/2/78¹]

[Filed 12/14/78, Notice 11/1/78—published 12/27/78, effective 1/31/79]

[Filed 9/26/80, Notice 7/9/80—published 10/15/80, effective 11/19/80]

[Filed 1/30/81, Notice 12/10/80—published 2/18/81, effective 3/25/81]

[Filed 5/22/81, Notice 3/18/81—published 6/10/81, effective 7/15/81]

[Filed 9/18/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]

[Filed 11/20/81, Notice 8/19/81—published 12/9/81, effective 1/13/82]

[Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 1/13/82]

[Filed emergency 3/26/82—published 4/14/82, effective 3/26/82]

[Filed 3/26/82, Notice 1/6/82—published 4/14/82, effective 5/19/82]

[Filed 9/24/82, Notice 6/23/82—published 10/13/82, effective 11/17/82]

[Filed 11/18/82, Notice 10/13/82—published 12/8/82, effective 1/12/83]

[Filed 6/2/83, Notice 4/13/83—published 6/22/83, effective 7/27/83]

[Filed emergency 7/27/84—published 8/15/84, effective 7/27/84]

[Filed 10/19/84, Notice 8/15/84—published 11/7/84, effective 12/12/84]

[Filed 9/20/85, Notice 6/19/85—published 10/9/85, effective 11/13/85]

[Filed emergency 2/21/86—published 3/12/86, effective 2/21/86]

[Filed 5/30/86, Notice 3/12/86—published 6/18/86, effective 7/23/86]

[Filed emergency 6/26/87—published 7/15/87, effective 6/26/87]

[Filed 7/8/88, Notice 3/23/88—published 7/27/88, effective 8/31/88]

[Filed 10/28/88, Notice 8/10/88—published 11/16/88, effective 12/21/88]

[Filed 7/2/93, Notice 4/14/93—published 7/21/93, effective 8/25/93]
[Filed 2/25/94, Notice 9/29/93—published 3/16/94, effective 4/20/94]²
[Filed emergency 6/24/94—published 7/20/94, effective 6/24/94]
[Filed 8/25/95, Notice 6/7/95—published 9/13/95, effective 10/18/95]
[Filed 9/8/95, Notice 5/24/95—published 9/27/95, effective 11/1/95]
[Filed 3/6/98, Notice 11/19/97—published 3/25/98, effective 4/29/98]
[Filed 12/20/00, Notice 8/9/00—published 1/10/01, effective 2/14/01]
[Filed 6/22/01, Notice 3/21/01—published 7/11/01, effective 8/15/01]
[Filed 8/29/02, Notice 6/26/02—published 9/18/02, effective 10/23/02]
[Filed 3/9/06, Notice 2/1/06—published 3/29/06, effective 5/3/06]

[Filed Emergency After Notice ARC 8792B (Notice ARC 8628B, IAB 3/24/10), IAB 6/2/10, effective 7/1/10]

[Filed ARC 9534B (Notice ARC 9436B, IAB 3/23/11), IAB 6/1/11, effective 7/6/11]

- ¹ Effective date of Ch 3 delayed by the Administrative Rules Review Committee 70 days from 8/2/78. Delay suspended by the Administrative Rules Review Committee at their meeting held on 9/11/78.
- ² Effective date of 643—3.35(125) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 1994; on June 15, 1994, the Committee voted to delay the rule until adjournment of the 1995 General Assembly.

PROFESSIONAL LICENSURE DIVISION[645]

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

CHAPTERS 1 to 3

Reserved

CHAPTER 4

BOARD ADMINISTRATIVE PROCESSES

- 4.1(17A) Definitions
- 4.2(17A) Purpose of board
- 4.3(17A,147,272C) Organization of board and proceedings
- 4.4(17A) Official communications
- 4.5(17A) Office hours
- 4.6(21) Public meetings
- 4.7(147) Licensure by reciprocal agreement
- 4.8(147) Duplicate certificate or wallet card
- 4.9(147) Reissued certificate or wallet card
- 4.10(17A,147,272C) License denial
- 4.11(272C) Audit of continuing education
- 4.12(272C,83GA,SF2325) Automatic exemption
- 4.13(272C) Grounds for disciplinary action
- 4.14(272C) Continuing education exemption for disability or illness
- 4.15(147,272C) Order for physical, mental, or clinical competency examination or alcohol or drug screening
- 4.16(252J,261,272D) Noncompliance rules regarding child support, loan repayment and nonpayment of state debt

CHAPTER 5

FEES

- 5.1(147,152D) Athletic training license fees
- 5.2(147,158) Barbering license fees
- 5.3(147,154D) Behavioral science license fees
- 5.4(151) Chiropractic license fees
- 5.5(147,157) Cosmetology arts and sciences license fees
- 5.6(147,152A) Dietetics license fees
- 5.7(147,154A) Hearing aid dispensers license fees
- 5.8(147) Massage therapy license fees
- 5.9(147,156) Mortuary science license fees
- 5.10(147,155) Nursing home administrators license fees
- 5.11(147,148B) Occupational therapy license fees
- 5.12(147,154) Optometry license fees
- 5.13(147,148A) Physical therapy license fees
- 5.14(148C) Physician assistants license fees
- 5.15(147,149) Podiatry license fees
- 5.16(147,154B) Psychology license fees
- 5.17(147,152B) Respiratory care license fees
- 5.18(147,154E) Sign language interpreters and transliterators license fees
- 5.19(147,154C) Social work license fees
- 5.20(147) Speech pathology and audiology license fees

CHAPTER 6
PETITIONS FOR RULE MAKING

- 6.1(17A) Petition for rule making
6.2(17A) Inquiries

CHAPTER 7
AGENCY PROCEDURE FOR RULE MAKING

- 7.1(17A) Adoption by reference

CHAPTER 8
DECLARATORY ORDERS
(Uniform Rules)

- 8.1(17A) Petition for declaratory order
8.2(17A) Notice of petition
8.3(17A) Intervention
8.5(17A) Inquiries

CHAPTER 9
COMPLAINTS AND INVESTIGATIONS

- 9.1(272C) Complaints
9.2(272C) Report of malpractice claims or actions or disciplinary actions
9.3(272C) Report of acts or omissions
9.4(272C) Investigation of complaints or reports
9.5(17A,272C) Issuance of investigatory subpoenas
9.6(272C) Peer review committees
9.7(17A) Appearance

CHAPTER 10
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

- 10.1(17A,22) Definitions
10.3(17A,22) Requests for access to records
10.5(17A,22) Request for treatment of a record as a confidential record and its withholding from examination
10.6(17A,22) Procedures by which additions, dissents, or objections may be entered into certain records
10.9(17A,22) Disclosures without the consent of the subject
10.10(17A,22) Routine use
10.11(17A,22) Consensual disclosure of confidential records
10.12(17A,22) Release to subject
10.13(17A,22) Availability of records
10.14(17A,22) Personally identifiable information
10.15(22) Other groups of records routinely available for public inspection
10.16(17A,22) Applicability

CHAPTER 11
CONTESTED CASES

- 11.1(17A) Scope and applicability
11.2(17A) Definitions
11.3(17A) Time requirements
11.4(17A) Probable cause
11.5(17A) Legal review
11.6(17A) Statement of charges and notice of hearing
11.7(17A,272C) Legal representation

11.8(17A,272C)	Presiding officer in a disciplinary contested case
11.9(17A)	Presiding officer in a nondisciplinary contested case
11.10(17A)	Disqualification
11.11(17A)	Consolidation—severance
11.12(17A)	Answer
11.13(17A)	Service and filing
11.14(17A)	Discovery
11.15(17A,272C)	Issuance of subpoenas in a contested case
11.16(17A)	Motions
11.17(17A)	Prehearing conferences
11.18(17A)	Continuances
11.19(17A,272C)	Hearing procedures
11.20(17A)	Evidence
11.21(17A)	Default
11.22(17A)	Ex parte communication
11.23(17A)	Recording costs
11.24(17A)	Interlocutory appeals
11.25(17A)	Applications for rehearing
11.26(17A)	Stays of agency actions
11.27(17A)	No factual dispute contested cases
11.28(17A)	Emergency adjudicative proceedings
11.29(17A)	Appeal
11.30(272C)	Publication of decisions
11.31(272C)	Reinstatement
11.32(17A,272C)	License denial

CHAPTER 12
INFORMAL SETTLEMENT

12.1(17A,272C)	Informal settlement
----------------	---------------------

CHAPTER 13
DISCIPLINE

13.1(272C)	Method of discipline
13.2(272C)	Discretion of board
13.3(272C)	Conduct of persons attending meetings

CHAPTERS 14 and 15
Reserved

CHAPTER 16
IMPAIRED PRACTITIONER REVIEW COMMITTEE

16.1(272C)	Definitions
16.2(272C)	Purpose
16.3(272C)	Composition of the committee
16.4(272C)	Organization of the committee
16.5(272)	Eligibility
16.6(272C)	Meetings
16.7(272C)	Terms of participation
16.8(272C)	Noncompliance
16.9(272C)	Practice restrictions
16.10(272C)	Limitations
16.11(272C)	Confidentiality

CHAPTER 17
MATERIALS FOR BOARD REVIEW

17.1(147) Materials for board review

CHAPTER 18
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

18.1(17A,147,272C) Definitions
 18.2(17A,147,272C) Scope of chapter
 18.3(17A,147,272C) Applicability of chapter
 18.4(17A,147,272C) Criteria for waiver or variance
 18.5(17A,147,272C) Filing of petition
 18.6(17A,147,272C) Content of petition
 18.7(17A,147,272C) Additional information
 18.8(17A,147,272C) Notice
 18.9(17A,147,272C) Hearing procedures
 18.10(17A,147,272C) Ruling
 18.11(17A,147,272C) Public availability
 18.12(17A,147,272C) Summary reports
 18.13(17A,147,272C) Cancellation of a waiver
 18.14(17A,147,272C) Violations
 18.15(17A,147,272C) Defense
 18.16(17A,147,272C) Judicial review

CHAPTERS 19 and 20
Reserved

BARBERS

CHAPTER 21
LICENSURE

21.1(158) Definitions
 21.2(158) Requirements for licensure
 21.3(158) Examination requirements for barbers and barber instructors
 21.4 Reserved
 21.5(158) Licensure by endorsement
 21.6 Reserved
 21.7(158) Temporary permits to practice barbering
 21.8(158) Demonstrator's permit
 21.9(158) License renewal
 21.10 Reserved
 21.11(158) Requirements for a barbershop license
 21.12(158) Barbershop license renewal
 21.13 to 21.15 Reserved
 21.16(17A,147,272C) License reactivation
 21.17(17A,147,272C) Reactivation of a barbershop license
 21.18(17A,147,272C) License reinstatement

CHAPTER 22
SANITATION

22.1(158) Definitions
 22.2(158) Posting of sanitation rules and inspection report
 22.3(147) Display of licenses
 22.4(158) Responsibilities of barbershop owner and supervisor
 22.5(158) Building standards

22.6(158)	Barbershops in residential buildings
22.7(158)	Barbershops adjacent to other businesses
22.8(142D,158)	Smoking
22.9(158)	Personal cleanliness
22.10(158)	Universal precautions
22.11(158)	Minimum equipment and supplies
22.12(158)	Disinfecting nonelectrical instruments and equipment
22.13(158)	Disinfecting electrical instruments
22.14(158)	Instruments and supplies that cannot be disinfected
22.15(158)	Semisolids, dusters, and styptics
22.16(158)	Disposal of materials
22.17(158)	Prohibited hazardous substances and use of products
22.18(158)	Proper protection of neck
22.19(158)	Proper laundering and storage
22.20(158)	Pets
22.21(158)	Records

CHAPTER 23 BARBER SCHOOLS

23.1(158)	Definitions
23.2(158)	Licensing for barber schools
23.3(158)	School license renewal
23.4(272C)	Inactive school license
23.5	Reserved
23.6(158)	Physical requirements for barber schools
23.7(158)	Minimum equipment requirements
23.8(158)	Course of study requirements
23.9(158)	Instructors
23.10(158)	Students
23.11(158)	Attendance requirements
23.12(158)	Graduate of a barber school
23.13(147)	Records requirements
23.14(158)	Public notice
23.15(158)	Apprenticeship

CHAPTER 24 CONTINUING EDUCATION FOR BARBERS

24.1(158)	Definitions
24.2(158)	Continuing education requirements
24.3(158,272C)	Standards

CHAPTER 25 DISCIPLINE FOR BARBERS, BARBER INSTRUCTORS, BARBERSHOPS AND BARBER SCHOOLS

25.1(158)	Definitions
25.2(272C)	Grounds for discipline
25.3(158,272C)	Method of discipline
25.4(272C)	Discretion of board

CHAPTERS 26 to 30 Reserved

BEHAVIORAL SCIENTISTS

CHAPTER 31

LICENSURE OF MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

31.1(154D)	Definitions
31.2(154D)	Requirements for permanent and temporary licensure
31.3(154D)	Examination requirements
31.4(154D)	Educational qualifications for marital and family therapists
31.5(154D)	Clinical experience requirements for marital and family therapists
31.6(154D)	Educational qualifications for mental health counselors
31.7(154D)	Clinical experience requirements for mental health counselors
31.8(154D)	Licensure by endorsement
31.9	Reserved
31.10(147)	License renewal
31.11	Reserved
31.12(147)	Licensee record keeping
31.13 to 31.15	Reserved
31.16(17A,147,272C)	License reactivation
31.17(17A,147,272C)	License reinstatement
31.18(154D)	Marital and family therapy and mental health counselor services subject to regulation

CHAPTER 32

CONTINUING EDUCATION FOR MARITAL AND
FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

32.1(272C)	Definitions
32.2(272C)	Continuing education requirements
32.3(154D,272C)	Standards

CHAPTER 33

DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

33.1(154D)	Definitions
33.2(154D,272C)	Grounds for discipline
33.3(147,272C)	Method of discipline
33.4(272C)	Discretion of board

CHAPTERS 34 to 40

Reserved

CHIROPRACTIC

CHAPTER 41

LICENSURE OF CHIROPRACTIC PHYSICIANS

41.1(151)	Definitions
41.2(151)	Requirements for licensure
41.3(151)	Examination requirements
41.4(151)	Educational qualifications
41.5(151)	Temporary certificate
41.6(151)	Licensure by endorsement
41.7	Reserved
41.8(151)	License renewal
41.9 to 41.13	Reserved

- 41.14(17A,147,272C) License reactivation
- 41.15(17A,147,272C) License reinstatement

CHAPTER 42

COLLEGES FOR CHIROPRACTIC PHYSICIANS

- 42.1(151) Definitions
- 42.2(151) Board-approved chiropractic colleges
- 42.3(151) Practice by chiropractic interns and chiropractic residents
- 42.4(151) Approved chiropractic preceptorship program
- 42.5(151) Approved chiropractic physician preceptors
- 42.6(151) Termination of preceptorship

CHAPTER 43

PRACTICE OF CHIROPRACTIC PHYSICIANS

- 43.1(151) Definitions
- 43.2(147,272C) Principles of chiropractic ethics
- 43.3(514F) Utilization and cost control review
- 43.4(151) Chiropractic insurance consultant
- 43.5(151) Acupuncture
- 43.6 Reserved
- 43.7(151) Adjunctive procedures
- 43.8(151) Physical examination
- 43.9(151) Gonad shielding
- 43.10(151) Record keeping
- 43.11(151) Billing procedures
- 43.12(151) Chiropractic assistants

CHAPTER 44

CONTINUING EDUCATION FOR CHIROPRACTIC PHYSICIANS

- 44.1(151) Definitions
- 44.2(272C) Continuing education requirements
- 44.3(151,272C) Standards

CHAPTER 45

DISCIPLINE FOR CHIROPRACTIC PHYSICIANS

- 45.1(151) Definitions
- 45.2(151,272C) Grounds for discipline
- 45.3(147,272C) Method of discipline
- 45.4(272C) Discretion of board

CHAPTERS 46 to 59

Reserved

COSMETOLOGISTS

CHAPTER 60

LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS,
MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS
OF COSMETOLOGY ARTS AND SCIENCES

- 60.1(157) Definitions
- 60.2(157) Requirements for licensure
- 60.3(157) Criteria for licensure in specific practice disciplines
- 60.4(157) Practice-specific training requirements
- 60.5(157) Licensure restrictions relating to practice

60.6(157)	Consent form requirements
60.7(157)	Licensure by endorsement
60.8(157)	License renewal
60.9(157)	Temporary permits
60.10 to 60.16	Reserved
60.17(17A,147,272C)	License reactivation
60.18(17A,147,272C)	License reinstatement

CHAPTER 61

LICENSURE OF SALONS AND SCHOOLS
OF COSMETOLOGY ARTS AND SCIENCES

61.1(157)	Definitions
61.2(157)	Salon licensing
61.3(157)	Salon license renewal
61.4(272C)	Inactive salon license
61.5(157)	Display requirements for salons
61.6(147)	Duplicate certificate or wallet card for salons
61.7(157)	Licensure for schools of cosmetology arts and sciences
61.8(157)	School license renewal
61.9(272C)	Inactive school license
61.10(157)	Display requirements for schools
61.11	Reserved
61.12(157)	Physical requirements for schools of cosmetology arts and sciences
61.13(157)	Minimum equipment requirements
61.14(157)	Course of study requirements
61.15(157)	Instructors
61.16(157)	Student instructors
61.17(157)	Students
61.18(157)	Attendance requirements
61.19(157)	Accelerated learning
61.20(157)	Mentoring program
61.21(157)	Graduate of a school of cosmetology arts and sciences
61.22(157)	Records requirements
61.23(157)	Classrooms used for other educational purposes
61.24(157)	Public notice

CHAPTER 62

Reserved

CHAPTER 63

SANITATION FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

63.1(157)	Definitions
63.2(157)	Posting of sanitation rules and inspection report
63.3(157)	Responsibilities of salon owners
63.4(157)	Responsibilities of licensees
63.5(157)	Joint responsibility
63.6(157)	Building standards
63.7(157)	Salons in residential buildings
63.8(157)	Salons adjacent to other businesses
63.9(157)	Smoking
63.10(157)	Personal cleanliness
63.11(157)	Universal precautions
63.12(157)	Blood spill procedures

63.13(157)	Disinfecting instruments and equipment
63.14(157)	Instruments and supplies that cannot be disinfected
63.15(157)	Sterilizing instruments
63.16(157)	Sanitary methods for creams, cosmetics and applicators
63.17	Reserved
63.18(157)	Prohibited hazardous substances and use of products and equipment
63.19(157)	Proper protection of neck
63.20(157)	Proper laundering and storage
63.21(157)	Pets
63.22(157)	General maintenance
63.23(157)	Records
63.24(157)	Salons and schools providing electrology or esthetics
63.25(157)	Cleaning and disinfecting circulating and noncirculating tubs, bowls, and spas
63.26(157)	Paraffin wax

CHAPTER 64

CONTINUING EDUCATION FOR COSMETOLOGY ARTS AND SCIENCES

64.1(157)	Definitions
64.2(157)	Continuing education requirements
64.3(157,272C)	Standards

CHAPTER 65

DISCIPLINE FOR COSMETOLOGY ARTS AND SCIENCES LICENSEES,
INSTRUCTORS, SALONS, AND SCHOOLS

65.1(157,272C)	Definitions
65.2(157,272C)	Grounds for discipline
65.3(157,272C)	Method of discipline
65.4(272C)	Discretion of board
65.5(157)	Civil penalties against nonlicensees

CHAPTERS 66 to 80

Reserved

DIETITIANS

CHAPTER 81

LICENSURE OF DIETITIANS

81.1(152A)	Definitions
81.2(152A)	Nutrition care
81.3(152A,272C)	Principles
81.4(152A)	Requirements for licensure
81.5(152A)	Educational qualifications
81.6(152A)	Supervised experience
81.7(152A)	Licensure by endorsement
81.8	Reserved
81.9(152A)	License renewal
81.10 to 81.14	Reserved
81.15(17A,147,272C)	License reactivation
81.16(17A,147,272C)	License reinstatement

CHAPTER 82
CONTINUING EDUCATION FOR DIETITIANS

- 82.1(152A) Definitions
82.2(152A) Continuing education requirements
82.3(152A,272C) Standards

CHAPTER 83
DISCIPLINE FOR DIETITIANS

- 83.1(152A) Definitions
83.2(152A,272C) Grounds for discipline
83.3(152A,272C) Method of discipline
83.4(272C) Discretion of board

CHAPTERS 84 to 99
Reserved

FUNERAL DIRECTORS

CHAPTER 100
PRACTICE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS,
AND CREMATION ESTABLISHMENTS

- 100.1(156) Definitions
100.2(156) Funeral director duties
100.3(156) Permanent identification tag
100.4(142,156) Removal and transfer of dead human remains and fetuses
100.5(135,144) Burial transit permits
100.6(156) Prepreparation and embalming activities
100.7(156) Arranging and directing funeral and memorial ceremonies
100.8(142,156) Unclaimed dead human remains for scientific use
100.9(144) Disinterments
100.10(156) Cremation of human remains and fetuses

CHAPTER 101
LICENSURE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS, AND
CREMATION ESTABLISHMENTS

- 101.1(156) Definitions
101.2(156) Requirements for licensure
101.3(156) Educational qualifications
101.4(156) Examination requirements
101.5(147,156) Internship and preceptorship
101.6(156) Student practicum
101.7(156) Funeral establishment license or cremation establishment license or both establishment licenses
101.8(156) Licensure by endorsement
101.9 Reserved
101.10(156) License renewal
101.11 and 101.12 Reserved
101.13(272C) Renewal of a funeral establishment license or cremation establishment license or both establishment licenses
101.14(272C) Inactive funeral establishment license or cremation establishment license or both establishment licenses
101.15(17A,147,272C) License reinstatement
101.16 and 101.17 Reserved

- 101.18(17A,147,272C) License reactivation
- 101.19(17A,147,272C) License reinstatement

CHAPTER 102

CONTINUING EDUCATION FOR FUNERAL DIRECTORS

- 102.1(272C) Definitions
- 102.2(272C) Continuing education requirements
- 102.3(156,272C) Standards
- 102.4 Reserved
- 102.5(83GA,SF2325) Automatic exemption

CHAPTER 103

DISCIPLINARY PROCEEDINGS

- 103.1(156) Definitions
- 103.2(17A,147,156,272C) Disciplinary authority
- 103.3(17A,147,156,272C) Grounds for discipline against funeral directors
- 103.4(17A,147,156,272C) Grounds for discipline against funeral establishments and cremation establishments
- 103.5(17A,147,156,272C) Method of discipline
- 103.6(17A,147,156,272C) Board discretion in imposing disciplinary sanctions
- 103.7(156) Order for mental, physical, or clinical competency examination or alcohol or drug screening
- 103.8(17A,147,156,272C) Informal discussion

CHAPTER 104

ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

- 104.1(156) Civil penalties against nonlicensees
- 104.2(156) Unlawful practices
- 104.3(156) Investigations
- 104.4(156) Subpoenas
- 104.5(156) Notice of intent to impose civil penalties
- 104.6(156) Requests for hearings
- 104.7(156) Factors to consider
- 104.8(156) Enforcement options

CHAPTERS 105 to 120

Reserved

HEARING AID DISPENSERS

CHAPTER 121

LICENSURE OF HEARING AID DISPENSERS

- 121.1(154A) Definitions
- 121.2(154A) Temporary permits
- 121.3(154A) Supervision requirements
- 121.4(154A) Requirements for initial licensure
- 121.5(154A) Examination requirements
- 121.6(154A) Licensure by endorsement
- 121.7 Reserved
- 121.8(154A) Display of license
- 121.9(154A) License renewal
- 121.10 to 121.13 Reserved
- 121.14(17A,147,272C) License reactivation
- 121.15(17A,147,272C) License reinstatement

CHAPTER 122
CONTINUING EDUCATION FOR HEARING AID DISPENSERS

- 122.1(154A) Definitions
- 122.2(154A) Continuing education requirements
- 122.3(154A,272C) Standards

CHAPTER 123
PRACTICE OF HEARING AID DISPENSING

- 123.1(154A) Definitions
- 123.2(154A) Requirements prior to sale of a hearing aid
- 123.3(154A) Requirements for sales receipt
- 123.4(154A) Requirements for record keeping

CHAPTER 124
DISCIPLINE FOR HEARING AID DISPENSERS

- 124.1(154A,272C) Definitions
- 124.2(154A,272C) Grounds for discipline
- 124.3(154A,272C) Method of discipline
- 124.4(272C) Discretion of board

CHAPTERS 125 to 130
Reserved

MASSAGE THERAPISTS

CHAPTER 131
LICENSURE OF MASSAGE THERAPISTS

- 131.1(152C) Definitions
- 131.2(152C) Requirements for licensure
- 131.3(152C) Educational qualifications
- 131.4(152C) Examination requirements
- 131.5(152C) Temporary licensure of a licensee from another state
- 131.6(152C) Licensure by endorsement
- 131.7 Reserved
- 131.8(152C) License renewal
- 131.9 to 131.13 Reserved
- 131.14(17A,147,272C) License reactivation
- 131.15(17A,147,272C) License reinstatement

CHAPTER 132
MASSAGE THERAPY EDUCATION CURRICULUM

- 132.1(152C) Definitions
- 132.2(152C) Application for approval of massage therapy education curriculum
- 132.3(152C) Curriculum requirements
- 132.4(152C) Student clinical practicum standards
- 132.5(152C) School certificate or diploma
- 132.6(152C) School records retention
- 132.7(152C) Massage school curriculum compliance
- 132.8(152C) Denial or withdrawal of approval

CHAPTER 133

CONTINUING EDUCATION FOR MASSAGE THERAPISTS

- 133.1(152C) Definitions
- 133.2(152C) Continuing education requirements
- 133.3(152C,272C) Continuing education criteria

CHAPTER 134

DISCIPLINE FOR MASSAGE THERAPISTS

- 134.1(152C) Definitions
- 134.2(152C,272C) Grounds for discipline
- 134.3(147,272C) Method of discipline
- 134.4(272C) Discretion of board
- 134.5(152C) Civil penalties

CHAPTERS 135 to 140

Reserved

NURSING HOME ADMINISTRATORS

CHAPTER 141

LICENSURE OF NURSING HOME ADMINISTRATORS

- 141.1(155) Definitions
- 141.2(155) Requirements for licensure
- 141.3(147,155) Examination requirements
- 141.4(155) Educational qualifications
- 141.5(155) Practicum experience
- 141.6(155) Provisional administrator
- 141.7(155) Licensure by endorsement
- 141.8(147,155) Licensure by reciprocal agreement
- 141.9(147,155) License renewal
- 141.10 to 141.14 Reserved
- 141.15(17A,147,272C) License reactivation
- 141.16(17A,147,272C) License reinstatement

CHAPTER 142

Reserved

CHAPTER 143

CONTINUING EDUCATION FOR NURSING HOME ADMINISTRATION

- 143.1(272C) Definitions
- 143.2(272C) Continuing education requirements
- 143.3(155,272C) Standards
- 143.4(155,272C) Audit of continuing education report
- 143.5(155,272C) Automatic exemption
- 143.6(272C) Continuing education exemption for disability or illness
- 143.7(155,272C) Grounds for disciplinary action

CHAPTER 144

DISCIPLINE FOR NURSING HOME ADMINISTRATORS

- 144.1(155) Definitions
- 144.2(155,272C) Grounds for discipline
- 144.3(155,272C) Method of discipline

- 144.4(272C) Discretion of board
 144.5(155) Order for mental, physical, or clinical competency examination or alcohol or drug screening

CHAPTERS 145 to 179

Reserved

OPTOMETRISTS

CHAPTER 180

LICENSURE OF OPTOMETRISTS

- 180.1(154) Definitions
 180.2(154) Requirements for licensure
 180.3(154) Licensure by endorsement
 180.4 Reserved
 180.5(154) License renewal
 180.6 to 180.10 Reserved
 180.11(17A,147,272C) License reactivation
 180.12(17A,147,272C) License reinstatement

CHAPTER 181

CONTINUING EDUCATION FOR OPTOMETRISTS

- 181.1(154) Definitions
 181.2(154) Continuing education requirements
 181.3(154,272C) Standards

CHAPTER 182

PRACTICE OF OPTOMETRISTS

- 182.1(154) Code of ethics
 182.2(154,272C) Record keeping
 182.3(154) Furnishing prescriptions
 182.4(155A) Prescription drug orders

CHAPTER 183

DISCIPLINE FOR OPTOMETRISTS

- 183.1(154) Definitions
 183.2(154,272C) Grounds for discipline
 183.3(147,272C) Method of discipline
 183.4(272C) Discretion of board

CHAPTERS 184 to 199

Reserved

PHYSICAL AND OCCUPATIONAL THERAPISTS

CHAPTER 200

LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

- 200.1(147) Definitions
 200.2(147) Requirements for licensure
 200.3 Reserved
 200.4(147) Examination requirements for physical therapists and physical therapist assistants
 200.5(147) Educational qualifications
 200.6(272C) Supervision requirements
 200.7(147) Licensure by endorsement
 200.8 Reserved

- 200.9(147) License renewal
- 200.10 to 200.14 Reserved
- 200.15(17A,147,272C) License reactivation
- 200.16(17A,147,272C) License reinstatement

CHAPTER 201

PRACTICE OF PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

- 201.1(148A,272C) Code of ethics for physical therapists and physical therapist assistants
- 201.2(147) Record keeping

CHAPTER 202

DISCIPLINE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

- 202.1(148A) Definitions
- 202.2(272C) Grounds for discipline
- 202.3(147,272C) Method of discipline
- 202.4(272C) Discretion of board

CHAPTER 203

CONTINUING EDUCATION FOR PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

- 203.1(272C) Definitions
- 203.2(148A) Continuing education requirements
- 203.3(148A,272C) Standards

CHAPTERS 204 and 205

Reserved

CHAPTER 206

LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 206.1(147) Definitions
- 206.2(147) Requirements for licensure
- 206.3(147) Limited permit to practice pending licensure
- 206.4(147) Applicant occupational therapist and occupational therapy assistant
- 206.5(147) Practice of occupational therapy limited permit holders and endorsement applicants prior to licensure
- 206.6(147) Examination requirements
- 206.7(147) Educational qualifications
- 206.8(272C) Supervision requirements
- 206.9(147) Occupational therapy assistant responsibilities
- 206.10(147) Licensure by endorsement
- 206.11 Reserved
- 206.12(147) License renewal
- 206.13 to 206.17 Reserved
- 206.18(17A,147,272C) License reactivation
- 206.19(17A,147,272C) License reinstatement

CHAPTER 207

CONTINUING EDUCATION FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 207.1(148B) Definitions
- 207.2(272C) Continuing education requirements
- 207.3(148B,272C) Standards

CHAPTER 208
PRACTICE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 208.1(148B,272C) Code of ethics for occupational therapists and occupational therapy assistants
208.2(147) Record keeping

CHAPTER 209
DISCIPLINE FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 209.1(148B) Definitions
209.2(272C) Grounds for discipline
209.3(147,272C) Method of discipline
209.4(272C) Discretion of board

CHAPTERS 210 to 219

Reserved

CHAPTER 220
LICENSURE OF PODIATRISTS

- 220.1(149) Definitions
220.2(149) Requirements for licensure
220.3(149) Written examinations
220.4(149) Educational qualifications
220.5(149) Title designations
220.6(147,149) Temporary license
220.7(149) Licensure by endorsement
220.8 Reserved
220.9(149) License renewal
220.10 to 220.14 Reserved
220.15(17A,147,272C) License reactivation
220.16(17A,147,272C) License reinstatement

CHAPTER 221

Reserved

CHAPTER 222
CONTINUING EDUCATION FOR PODIATRISTS

- 222.1(149,272C) Definitions
222.2(149,272C) Continuing education requirements
222.3(149,272C) Standards

CHAPTER 223
PRACTICE OF PODIATRY

- 223.1(149) Definitions
223.2(149) Requirements for administering conscious sedation
223.3(139A) Preventing HIV and HBV transmission
223.4(149) Unlicensed graduate of a podiatric college

CHAPTER 224
DISCIPLINE FOR PODIATRISTS

- 224.1(149) Definitions
224.2(149,272C) Grounds for discipline
224.3(147,272C) Method of discipline
224.4(272C) Discretion of board

CHAPTERS 225 to 239

Reserved

PSYCHOLOGISTS

CHAPTER 240

LICENSURE OF PSYCHOLOGISTS

240.1(154B)	Definitions
240.2(154B)	Requirements for licensure
240.3(154B)	Educational qualifications
240.4(154B)	Examination requirements
240.5(154B)	Title designations
240.6(154B)	Supervised professional experience
240.7(154B)	Certified health service provider in psychology
240.8(154B)	Exemption to licensure
240.9(154B)	Psychologists' supervision of unlicensed persons in a practice setting
240.10(147)	Licensure by endorsement
240.11(147)	Licensure by reciprocal agreement
240.12(147)	License renewal
240.13 to 240.17	Reserved
240.18(17A,147,272C)	License reactivation
240.19(17A,147,272C)	License reinstatement

CHAPTER 241

CONTINUING EDUCATION FOR PSYCHOLOGISTS

241.1(272C)	Definitions
241.2(272C)	Continuing education requirements
241.3(154B,272C)	Standards

CHAPTER 242

DISCIPLINE FOR PSYCHOLOGISTS

242.1(154B)	Definitions
242.2(147,272C)	Grounds for discipline
242.3(147,272C)	Method of discipline
242.4(272C)	Discretion of board
242.5(154B)	Order for mental, physical, or clinical competency examination or alcohol or drug screening

CHAPTERS 243 to 260

Reserved

RESPIRATORY CARE PRACTITIONERS

CHAPTER 261

LICENSURE OF RESPIRATORY CARE PRACTITIONERS

261.1(152B)	Definitions
261.2(152B)	Requirements for licensure
261.3(152B)	Educational qualifications
261.4(152B)	Examination requirements
261.5(152B)	Students
261.6(152B)	Licensure by endorsement
261.7	Reserved
261.8(152B)	License renewal
261.9 to 261.13	Reserved

- 261.14(17A,147,272C) License reactivation
- 261.15(17A,147,272C) License reinstatement

CHAPTER 262

CONTINUING EDUCATION FOR RESPIRATORY CARE PRACTITIONERS

- 262.1(152B,272C) Definitions
- 262.2(152B,272C) Continuing education requirements
- 262.3(152B,272C) Standards
- 262.4(152B,272C) Audit of continuing education report
- 262.5(152B,272C) Automatic exemption
- 262.6(152B,272C) Grounds for disciplinary action
- 262.7(152B,272C) Continuing education exemption for disability or illness

CHAPTER 263

DISCIPLINE FOR RESPIRATORY CARE PRACTITIONERS

- 263.1(152B) Definitions
- 263.2(152B,272C) Grounds for discipline
- 263.3(147,272C) Method of discipline
- 263.4(272C) Discretion of board

CHAPTER 264

Reserved

CHAPTER 265

PRACTICE OF RESPIRATORY CARE PRACTITIONERS

- 265.1(152B,272C) Code of ethics
- 265.2(152B,272C) Intravenous administration

CHAPTERS 266 to 279

Reserved

SOCIAL WORKERS

CHAPTER 280

LICENSURE OF SOCIAL WORKERS

- 280.1(154C) Definitions
- 280.2(154C) Social work services subject to regulation
- 280.3(154C) Requirements for licensure
- 280.4(154C) Written examination
- 280.5(154C) Educational qualifications
- 280.6(154C) Supervised professional practice for the LISW
- 280.7(154C) Licensure by endorsement
- 280.8 Reserved
- 280.9(154C) License renewal
- 280.10 to 280.13 Reserved
- 280.14(17A,147,272C) License reactivation
- 280.15(17A,147,272C) License reinstatement

CHAPTER 281

CONTINUING EDUCATION FOR SOCIAL WORKERS

- 281.1(154C) Definitions
- 281.2(154C) Continuing education requirements
- 281.3(154C,272C) Standards

CHAPTER 282
PRACTICE OF SOCIAL WORKERS

- 282.1(154C) Definitions
282.2(154C) Rules of conduct

CHAPTER 283
DISCIPLINE FOR SOCIAL WORKERS

- 283.1(154B) Definitions
283.2(272C) Grounds for discipline
283.3(147,272C) Method of discipline
283.4(272C) Discretion of board

CHAPTERS 284 to 299

Reserved

SPEECH PATHOLOGISTS AND AUDIOLOGISTS

CHAPTER 300
LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 300.1(147) Definitions
300.2(147) Speech pathology and audiology services subject to regulation
300.3(147) Requirements for licensure
300.4(147) Educational qualifications
300.5(147) Examination requirements
300.6(147) Temporary clinical license
300.7(147) Temporary permit
300.8(147) Use of assistants
300.9(147) Licensure by endorsement
300.10 Reserved
300.11(147) License renewal
300.12 to 300.16 Reserved
300.17(17A,147,272C) License reactivation
300.18(17A,147,272C) License reinstatement

CHAPTERS 301 and 302

Reserved

CHAPTER 303
CONTINUING EDUCATION FOR SPEECH PATHOLOGISTS
AND AUDIOLOGISTS

- 303.1(147) Definitions
303.2(147) Continuing education requirements
303.3(147,272C) Standards

CHAPTER 304
DISCIPLINE FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 304.1(147) Definitions
304.2(272C) Grounds for discipline
304.3(272C) Method of discipline
304.4(272C) Discretion of board

CHAPTERS 305 to 325

Reserved

PHYSICIAN ASSISTANTS

CHAPTER 326

LICENSURE OF PHYSICIAN ASSISTANTS

326.1(148C)	Definitions
326.2(148C)	Requirements for licensure
326.3(148C)	Temporary licensure
326.4(148C)	Licensure by endorsement
326.5	Reserved
326.6(148C)	Examination requirements
326.7(148C)	Educational qualifications
326.8(148C)	Supervision requirements
326.9(148C)	License renewal
326.10 to 326.14	Reserved
326.15(148C)	Use of title
326.16(148C)	Address change
326.17(148C)	Student physician assistant
326.18(148C)	Recognition of an approved program
326.19(17A,147,272C)	License reactivation
326.20(17A,147,272C)	License reinstatement

CHAPTER 327

PRACTICE OF PHYSICIAN ASSISTANTS

327.1(148C)	Duties
327.2(148C)	Prohibition
327.3	Reserved
327.4(148C)	Remote medical site
327.5(147)	Identification as a physician assistant
327.6(147)	Prescription requirements
327.7(147)	Supplying—requirements for containers, labeling, and records

CHAPTER 328

CONTINUING EDUCATION FOR PHYSICIAN ASSISTANTS

328.1(148C)	Definitions
328.2(148C)	Continuing education requirements
328.3(148C,272C)	Standards

CHAPTER 329

DISCIPLINE FOR PHYSICIAN ASSISTANTS

329.1(148C)	Definitions
329.2(148C,272C)	Grounds for discipline
329.3(147,272C)	Method of discipline
329.4(272C)	Discretion of board

CHAPTERS 330 to 350

Reserved

ATHLETIC TRAINERS

CHAPTER 351

LICENSURE OF ATHLETIC TRAINERS

351.1(152D)	Definitions
351.2(152D)	Requirements for licensure
351.3(152D)	Educational qualifications

351.4(152D)	Examination requirements
351.5(152D)	Documentation of physician direction
351.6(152D)	Athletic training plan for direct service
351.7(152D)	Licensure by endorsement
351.8	Reserved
351.9(147)	License renewal
351.10(272C)	Exemptions for inactive practitioners
351.11 and 351.12	Reserved
351.13(272C)	Lapsed licenses
351.14	Reserved
351.15(17A,147,272C)	License reactivation
351.16(17A,147,272C)	License reinstatement

CHAPTER 352

CONTINUING EDUCATION FOR ATHLETIC TRAINERS

352.1(272C)	Definitions
352.2(152D)	Continuing education requirements
352.3(152D,272C)	Standards
352.4(152D,272C)	Audit of continuing education report
352.5 and 352.6	Reserved
352.7(152D,272C)	Continuing education waiver for active practitioners
352.8(152D,272C)	Continuing education exemption for inactive practitioners
352.9	Reserved
352.10(152D,272C)	Reinstatement of inactive practitioners
352.11(272C)	Hearings

CHAPTER 353

DISCIPLINE FOR ATHLETIC TRAINERS

353.1(152D)	Definitions
353.2(152D,272C)	Grounds for discipline
353.3(152D,272C)	Method of discipline
353.4(272C)	Discretion of board

CHAPTERS 354 to 360

Reserved

SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

CHAPTER 361

LICENSURE OF SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

361.1(154E)	Definitions
361.2(154E)	Requirements for licensure
361.3(154E)	Licensure by endorsement
361.4	Reserved
361.5(154E)	License renewal
361.6 to 361.8	Reserved
361.9(17A,147,272C)	License reactivation
361.10(17A,147,272C)	License reinstatement

CHAPTER 362
CONTINUING EDUCATION FOR SIGN LANGUAGE INTERPRETERS AND
TRANSLITERATORS

- 362.1(154E,272C) Definitions
- 362.2(154E,272C) Continuing education requirements
- 362.3(154E,272C) Standards

CHAPTER 363
DISCIPLINE FOR SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

- 363.1(154E) Definitions
- 363.2(154E,272C) Grounds for discipline
- 363.3(147,272C) Method of discipline
- 363.4(272C) Discretion of board

BEHAVIORAL SCIENTISTS

CHAPTER 31	LICENSURE OF MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS
CHAPTER 32	CONTINUING EDUCATION FOR MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS
CHAPTER 33	DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

CHAPTER 31
LICENSURE OF MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

[Prior to 1/30/02, see 645—Chapter 30]

645—31.1(154D) Definitions. For purposes of these rules, the following definitions shall apply:

“*ACA*” means the American Counseling Association.

“*Active license*” means a license that is current and has not expired.

“*AMFTRB*” means the Association of Marital and Family Therapy Regulatory Boards.

“*Board*” means the board of behavioral science.

“*CCE*” means the Center for Credentialing and Education, Inc.

“*Course*” means three graduate semester credit hours.

“*CRCC*” means the Commission on Rehabilitation Counselor Certification.

“*Department*” means the department of public health.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a marital and family therapist or mental health counselor in the state of Iowa.

“*License expiration date*” means September 30 of even-numbered years.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is or has been licensed in another state.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of marital and family therapists and mental health counselors who are mandatory reporters. 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.

“*Mental health setting*” means a behavioral health setting where an applicant is providing mental health services including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues.

“*NBCC*” means the National Board for Certified Counselors.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 31.16(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of behavioral science to license persons who have the same or similar qualifications to those required in Iowa.

“*Reinstatement*” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“*Temporary license*” means a license to practice marital and family therapy or mental health counseling under direct supervision of a qualified supervisor as determined by the board by rule to fulfill the postgraduate supervised clinical experience requirement in accordance with this chapter.
[ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.2(154D) Requirements for permanent and temporary licensure. The following criteria shall apply to licensure:

31.2(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board’s Web site (<http://www.idph.state.ia.us/licensure>) or directly from the board office. All applications shall be sent to the Board of Behavioral Science, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

31.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

31.2(3) Each application shall be accompanied by the appropriate fees payable to the Board of Behavioral Science. The fees are nonrefundable.

31.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board of behavioral science have been received by the board or an equivalency evaluation completed by the Center for Credentialing and Education, Inc. (CCE) has been received by the board. The applicant shall present proof of meeting the educational requirements. Documentation of such proof shall be on file in the board office with the application and include one of the following:

a. For licensure as a marital and family therapist, an official transcript verifying completion of a marital and family therapy program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as defined in subrule 31.4(1) or an equivalency evaluation of the applicant's educational credentials completed by CCE as defined in subrule 31.4(2).

b. For licensure as a mental health counselor, an official transcript verifying completion of a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) as defined in subrule 31.6(1) or an equivalency evaluation of the applicant's educational credentials completed by CCE as defined in subrule 31.6(2).

31.2(5) The candidate for permanent licensure shall have the examination score sent directly from the testing service to the board. If the candidate for temporary licensure has not completed the examination prior to issuance of a temporary license, the candidate must successfully complete the examination before the temporary license expires.

31.2(6) The candidate for permanent licensure shall submit the required attestation of supervision forms documenting clinical experience as required in rule 645—31.5(154D) for marital and family therapy and rule 645—31.7(154D) for mental health counseling.

31.2(7) The candidate for temporary licensure for the purpose of fulfilling the postgraduate supervised clinical experience requirement must submit the Supervised Clinical Experience: Approval and Attestation form to the board and receive approval of the candidate's supervisor(s) prior to licensure. The temporary licensee must notify the board immediately in writing of any proposed change in supervisor(s) and obtain approval of any change in supervisor(s). Within 30 days of completion of the supervised clinical experience, the attestation of the completed supervised experience must be submitted to the board office.

31.2(8) A temporary license for the purpose of fulfilling the postgraduate supervised clinical experience requirement is valid for three years and may be renewed at the discretion of the board.

31.2(9) A licensee who was issued an initial permanent license within six months prior to the renewal shall not be required to renew the license until the renewal date two years later.

31.2(10) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

[ARC 8152B, IAB 9/23/09, effective 10/28/09]

645—31.3(154D) Examination requirements. The following criteria shall apply to the written examination(s):

31.3(1) In order to qualify for licensing, the applicant:

a. For a marital and family therapist license shall take and pass the Association of Marital and Family Therapy Regulatory Board (AMFTRB) Examination in Marital and Family Therapy.

b. For a mental health counselor license shall take and pass the National Counselor Examination of the NBCC, or the National Clinical Mental Health Counselor Examination of the NBCC, or the Certified Rehabilitation Counselor Examination of the CRCC.

31.3(2) Examination information will be provided when the applicant has been approved to take the examination.

31.3(3) The board will notify the applicant in writing of examination results.

31.3(4) Persons determined by the board not to have performed satisfactorily may apply for reexamination.

31.3(5) The passing score on the written examination shall be the passing point criterion established by the appropriate national testing authority at the time the test was administered.

645—31.4(154D) Educational qualifications for marital and family therapists. The applicant must complete the required semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.4(2); no course may be used more than once. The applicant must present proof of completion of the following educational requirements for licensure as a marital and family therapist:

31.4(1) *Accredited program.* Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.4(2) *Content-equivalent program.* Applicants must present an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in a mental health, behavioral science, or a counseling-related field from a college or university accredited by an agency recognized by the United States Department of Education, which is content-equivalent to a graduate degree in marital and family therapy. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent. After March 31, 2009, graduates from non-COAMFTE-accredited marital and family therapy programs shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site <http://cce-global.org>. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation. In order to qualify as a "content-equivalent" degree, a graduate transcript must document:

a. At least 9 semester hours or the equivalent in each of the three areas listed below:

(1) Theoretical foundations of marital and family therapy systems. Any course which deals primarily in areas such as family life cycle; theories of family development; marriage or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).

(2) Assessment and treatment in family and marital therapy. Any course which deals primarily in areas such as family therapy methodology; family assessment; treatment and intervention methods;

overview of major clinical theories of marital and family therapy, such as communications, contextual, experiential, object relations, strategic, structural, systemic, transgenerational.

(3) Human development. Any course which deals primarily in areas such as human development; personality theory; human sexuality. One course must be psychopathology.

b. At least 3 semester hours or the equivalent in each of the two areas listed below:

(1) Ethics and professional studies. Any course which deals primarily in areas such as professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and interprofessional cooperation; ethical issues in marital and family counseling; and family law.

(2) Research. Any course which deals primarily in areas such as research design, methods, statistics; research in marital and family studies and therapy.

If the applicant has taught a graduate-level course as outlined above at a college or university accredited by an agency recognized by the United States Department of Education or the Council on Professional Accreditation, that course will be credited toward the course requirements.

c. A graduate-level clinical practicum in marital and family therapy of at least 300 clock hours is required for all applicants.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.5(154D) Clinical experience requirements for marital and family therapists.

31.5(1) The supervised clinical experience shall:

a. Be a minimum of two years or the equivalent of full-time, postgraduate supervised clinical work experience in marital and family therapy;

b. Be completed following the practicum, internship, and all graduate coursework, with the exception of the thesis;

c. Include successful completion of 3,000 hours of marital and family therapy that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of marital and family therapy conducted in person with couples, families and individuals;

d. Include at least 100 of the 200 hours of clinical supervision as individual supervision;

e. Have 50 percent (100 hours) of the clinical supervision conducted in person; and

f. Have only supervised clinical contact credited for this requirement.

31.5(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

(1) Meet with the supervisor for a minimum of four hours per month;

(2) Offer documentation of supervised hours signed by the supervisor;

(3) Compute part-time employment on a prorated basis for the supervised professional experience;

(4) Have the background, training, and experience that is appropriate to the functions performed;

(5) Have supervision that is clearly distinguishable from personal psychotherapy and is contracted in order to serve professional/vocational goals;

(6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;

(7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and

(8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. The supervisor shall:

(1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure; or

(2) Be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(3) Be licensed under Iowa Code chapter 147 and have a minimum of three years of full-time professional work experience, including experience in marital and family therapy, as approved by the board; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

31.5(3) An applicant who has obtained American Association for Marriage and Family Therapy (AAMFT) clinical membership is considered to have met the clinical experience requirements of rule 645—31.5(154D). The applicant shall request that proof of current clinical membership be sent directly from AAMFT to the board.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.6(154D) Educational qualifications for mental health counselors. The applicant must complete three semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.6(2); no course may be used to fulfill more than one content area. The applicant must present proof of completion of the following educational requirements for licensure as a mental health counselor:

31.6(1) Accredited program. Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or equivalent quarter hours) or a doctoral degree in counseling with emphasis in mental health counseling from a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.6(2) Content-equivalent program. Applicants must present an official transcript verifying completion of a master's degree or a doctoral degree from a college or university accredited by an agency recognized by the United States Department of Education which is content-equivalent to a master's degree in counseling with emphasis in mental health counseling. Graduates from non-CACREP accredited mental health counseling programs shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site <http://cce-global.org>. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation.

a. The degree of an applicant who entered a program of study prior to July 1, 2012, will be considered "content-equivalent" if the degree includes 45 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Counseling theories.

- (2) Supervised counseling practicum.
- (3) Human growth and development. Studies that provide an understanding of the nature and needs of individuals at all developmental levels. Studies in this area include, but are not limited to, the following:
 1. Theories of human development across the life span;
 2. Major theories of personality development; and
 3. Human behavior, including an understanding of developmental crises, disability, psychopathology, and cultural factors as they affect both normal and abnormal behavior.
- (4) Social and cultural foundations. Studies that provide an understanding of issues and trends in a multicultural and diverse society. Studies in this area include, but are not limited to, the following:
 1. Multicultural and pluralistic trends, including characteristics and concerns of diverse groups;
 2. Attitudes and behavior based on factors such as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, gender, socioeconomic status, and intellectual ability; and
 3. Individual and group interventions with diverse populations.
- (5) Helping relationships. Studies that provide an understanding of counseling and consultation processes. Studies in this area include, but are not limited to, the following:
 1. Helping skills and counseling and consultation theories, including coverage of relevant research and factors considered in applications;
 2. Counselor or consultant characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills; and
 3. Client or consultee characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, traits, capabilities, life circumstances, and developmental levels.
- (6) Groups. Studies that provide an understanding of group development, dynamics, counseling theories, and group counseling methods and skills. Studies in this area include, but are not limited to, the following:
 1. Principles of group dynamics, including group process components, developmental stage theories, and group members' roles and behaviors;
 2. Group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;
 3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature; and
 4. Group counseling methods, including group counselor orientations and behaviors, ethical considerations, appropriate selection criteria and methods, and methods of evaluation of effectiveness.
- (7) Career and lifestyle development. Studies that provide an understanding of career development and the interrelationships among work, family, and other life factors. Studies in this area include, but are not limited to, the following:
 1. Career development theories and decision-making models;
 2. Career, avocational, educational and labor market sources, print media, computer-assisted career guidance, and computer-based career information;
 3. Career development program planning;
 4. Interrelationships among work, family, and other life factors such as multicultural and gender issues, as related to career development;
 5. Career and educational placement, follow-up and evaluation; and
 6. Assessment instruments relevant to career planning and decision making.
- (8) Diagnosis and assessment treatment procedures. Studies that provide an understanding of individual and group approaches to assessment and evaluation. Studies in this area include, but are not limited to, the following:
 1. Theoretical and historical bases for assessment techniques and methods of interpretation of appraisal data and information;

2. Types of educational and psychological appraisal as appropriate to the helping process;
3. Validity, including evidence for establishing content, construct, and empirical validity;
4. Reliability, including methods of establishing stability and internal and equivalence reliability;
5. Major appraisal methods, including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;

6. Psychometric statistics, including types of test scores, measures of central tendency, indices of variability, standard errors and correlations; and

7. Gender, ethnicity, language, disability, and cultural factors related to the assessment and evaluation of individuals and groups.

(9) Research and program evaluation. Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research. Studies in this area include, but are not limited to, the following:

1. Basic types of research methods, including qualitative, quantitative-descriptive, and quantitative-descriptive-experimental designs;

2. Basic statistics, including both univariate and bivariate hypothesis testing;

3. Uses of computers for data management and analyses; and

4. Ethical and legal considerations in research.

(10) Professional orientation. Studies that provide an understanding of all aspects of professional functioning, including history, roles, organizational structures, ethics, standards, and credentialing. Studies in this area include, but are not limited to, the following:

1. History of the helping professions, including significant factors and events;

2. Professional roles and functions, including similarities with and differences from other types of professionals;

3. Professional organizations (primarily ACA, its divisions, and its branches), including membership benefits, activities, services to members, and current emphases;

4. Ethical standards of the ACA and their evolution, legal issues, and applications to various professional activities (e.g., appraisal and group work);

5. Professional preparation standards and their evolution and current applications; and

6. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues.

(11) Supervised counseling internship that provides an opportunity for the trainee to perform under supervision a variety of activities that a regularly employed staff member in a setting would be expected to perform. A regularly employed staff member is defined as a person occupying the professional role to which the trainee is aspiring. The internship follows a supervised practicum experience. A three-semester-hour internship includes the following:

1. A minimum of 120 hours of direct service with clientele appropriate to the program of study;

2. A minimum of 1 hour per week of individual supervision, throughout the internship, usually performed by the on-site supervisor; and

3. A minimum of 1½ hours per week of group supervision, throughout the internship, usually performed by a program faculty member supervisor.

(12) Psychopathology. Studies that provide an understanding of the description, classification and diagnosis of behavior disorders and dysfunction. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;

2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;

3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;

4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and

5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

b. The degree of an applicant who entered a program of study on or after July 1, 2012, will be considered “content-equivalent” if the degree includes 60 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Professional orientation and ethical practice. Studies that provide an understanding of all of the following aspects of professional functioning:

1. History and philosophy of the counseling profession, including mental health counseling;

2. Professional roles, functions, and relationships of the mental health counselor with other human services providers, including strategies for interagency/interorganization collaboration and communication;

3. Counselors’ roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event;

4. Self-care strategies appropriate to the counselor role;

5. Counseling supervision models, practices, and processes;

6. Professional organizations (i.e., primarily ACA, its divisions, branches, and affiliates), including membership benefits, activities, services to members, and current emphases;

7. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;

8. The role and process of the professional mental health counselor advocating on behalf of the profession;

9. Advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and

10. Ethical standards of ACA and related entities, and applications of ethical and legal considerations in professional counseling.

(2) Social and cultural diversity. Studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural and diverse society including all of the following:

1. Multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;

2. Attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students’ understanding of self and culturally diverse clients;

3. Theories of multicultural counseling, identity development, and social justice;

4. Individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;

5. Counselors’ roles in developing cultural self-awareness, promoting cultural social justice, advocacy, and conflict resolution and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind or body; and

6. Counselors’ roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, including all of the following:

1. Theories of individual and family development and transitions across the life span;

2. Theories of learning and personality development including current understandings about neurobiological behavior;

3. Effects of crises, disasters, and other trauma-causing events on persons of all ages;
 4. Theories and models of individual, cultural, couple, family, and community resilience;
 5. A general framework for understanding exceptional abilities and strategies for differentiated interventions;
 6. Human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;
 7. Theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment; and
 8. Strategies for facilitating optimum development over the life span.
- (4) Career development. Studies that provide an understanding of career development and related life factors, including all of the following:
1. Career development theories and decision-making models;
 2. Career, avocational, educational, occupational and labor market information resources and career information systems;
 3. Career development program planning, organization, implementation, administration, and evaluation;
 4. Interrelationships among and between work, family, and other life roles and factors including the role of multicultural issues in career development;
 5. Career and educational planning, placement, follow-up, and evaluation;
 6. Assessment instruments and techniques relevant to career planning and decision making; and
 7. Career counseling processes, techniques, and resources, including those applicable to specific populations.
- (5) Helping relationships. Studies that provide an understanding of counseling processes in a multicultural society, including all of the following:
1. An orientation to wellness and prevention as desired counseling goals;
 2. Counselor characteristics and behaviors that influence helping processes;
 3. An understanding of essential interviewing and counseling skills;
 4. Counseling theories that provide the student with a model(s) to conceptualize client presentation and select appropriate counseling interventions. Students shall be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;
 5. A systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions;
 6. A general framework for understanding and practicing consultation; and
 7. Crisis intervention and suicide prevention models, including the use of psychological first-aid strategies.
- (6) Group work. Studies that provide both theoretical and experiential understanding of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society, including all of the following:
1. Principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;
 2. Group leadership or facilitation styles and approaches, including characteristics of various types of group leaders and leadership styles;
 3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;
 4. Group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness; and
 5. Experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term.
- (7) Assessment. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society, including the following:

1. Historical perspectives concerning the nature and meaning of assessment;
2. Basic concepts of standardized and nonstandardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, and behavioral observations;
3. Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;
4. Reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);
5. Validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);
6. Social and cultural factors related to the assessment and evaluation of individuals, groups, and specific populations;
7. Ethical strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling; and
8. An understanding of general principles and methods of case conceptualization, assessment, or diagnoses of mental and emotional status.

(8) Research and program evaluation. Studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

1. The importance of research in advancing the counseling profession;
2. Research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;
3. Statistical methods used in conducting research and program evaluation;
4. Principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;
5. Use of research to inform evidence-based practice; and
6. Ethical and culturally relevant strategies for interpreting and reporting the results of research and program evaluation studies.

(9) Diagnosis and treatment planning. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society. Studies in this area include, but are not limited to, the following:

1. The principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual;
2. The established diagnostic criteria for mental or emotional disorders that describe treatment modalities and placement criteria within the continuum of care;
3. The impact of co-occurring substance use disorders on medical and psychological disorders;
4. The relevance and potential biases of commonly used diagnostic tools as related to multicultural populations;
5. The appropriate use of diagnostic tools, including the current edition of the Diagnostic and Statistical Manual, to describe the symptoms and clinical presentation of clients with mental or emotional impairments;
6. The ability to conceptualize accurate multi-axial diagnoses of disorders presented by clients and discuss the differential diagnosis with collaborating professionals; and
7. The ability to differentiate between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events.

(10) Psychopathology. Studies that provide an understanding of emotional and mental disorders experienced by persons of all ages, characteristics of disorders, and common nosologies of emotional and mental disorders utilized within the U.S. health care system for diagnosis and treatment planning. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;

2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;

3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;

4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and

5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

(11) Practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;

2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;

3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and

4. Evaluation of the student's counseling performance throughout the practicum including documentation of a formal evaluation after the student completes the practicum.

(12) Internship. A graduate-level clinical supervised counseling internship in a mental health setting that requires students to complete a supervised internship of 600 clock hours that is begun after the student's successful completion of the practicum. The internship is intended to reflect the comprehensive work experience of a professional counselor appropriate to clinical mental health counseling. The internship provides an opportunity for the student to perform, under supervision, a variety of counseling activities that a mental health counselor is expected to perform. The student's internship includes all of the following:

1. At least 240 hours of direct service with clientele, including experience leading groups;

2. Weekly interaction that averages 1 hour per week of individual supervision or triadic supervision throughout the internship, usually performed by the on-site supervisor;

3. An average of 1½ hours per week of group supervision, provided on a regular schedule throughout the internship, usually performed by a program faculty member supervisor;

4. The opportunity for the student to become familiar with a variety of professional activities in addition to direct service (e.g., record keeping, supervision, information and referral, in-service and staff meetings);

5. The opportunity for the student to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the student's interactions with clients;

6. The opportunity for the student to gain supervised experience in the use of a variety of professional resources such as assessment instruments, technologies, print and nonprint media, professional literature, and research; and

7. Evaluation of the student's counseling performance throughout the internship including documentation of a formal evaluation by a program faculty member in consultation with the site supervisor after the student completes the internship.

31.6(3) *Foreign-trained marital and family therapists or mental health counselors.* Foreign-trained marital and family therapists or mental health counselors shall:

a. Provide an equivalency evaluation of their educational credentials by the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone (310)258-9451; Web site www.ierf.org or E-mail at

info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a mental health counselor program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.
[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.7(154D) Clinical experience requirements for mental health counselors.

31.7(1) The supervised clinical experience shall:

a. Be a minimum of two years or the equivalent of full-time, postgraduate supervised professional work experience in mental health counseling;

b. Be completed following completion of the practicum, internship, and all graduate coursework, with exception of the thesis;

c. Include successful completion of at least 3,000 hours of mental health counseling that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of mental health counseling conducted in person with couples, families and individuals;

d. Include at least 100 of the 200 hours of supervision as individual supervision;

e. Include 50 percent (100 hours) of all clinical supervision in person; and

f. Have only supervised clinical contact credited for this requirement.

31.7(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

(1) Meet with the supervisor a minimum of four hours per month;

(2) Offer documentation of supervised hours signed by the supervisor;

(3) Compute part-time employment on a prorated basis for the supervised professional experience;

(4) Have the background, training, and experience that are appropriate to the functions performed;

(5) Have supervision that is clearly distinguishable from personal counseling and is contracted in order to serve professional/vocational goals;

(6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;

(7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and

(8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. The supervisor:

(1) May be a licensed mental health counselor in Iowa with at least three years of postlicensure clinical experience; or

(2) Shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(3) May be an alternate supervisor who possesses qualifications equivalent to a licensed mental health counselor with at least three years of postlicensure clinical experience, including mental health professionals licensed pursuant to Iowa Code chapter 147; and

(4) Shall meet a minimum of four hours per month with the supervisee; and

- (5) Shall provide training that is appropriate to the functions to be performed; and
 - (6) Shall ensure that therapeutic work is done under the professional supervision of a supervisor;
- and
- (7) Shall not supervise any mental health counselor or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

31.7(3) Rescinded IAB 7/6/05, effective 8/10/05.

31.7(4) An applicant who has obtained Certified Clinical Mental Health Counselor status with the National Board for Certified Counselors (NBCC) is considered to have met the clinical experience requirements of rule 645—31.7(154D). The applicant shall ensure that proof of current certified clinical mental health counselor status be sent directly from NBCC to the board.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.8(154D) Licensure by endorsement. An applicant who has been a licensed marriage and family therapist or mental health counselor under the laws of another jurisdiction may file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

1. Submits to the board a completed application;
2. Pays the licensure fee;
3. Shows evidence of licensure requirements that are similar to those required in Iowa;
4. Provides official transcripts sent directly from the school to the board verifying completion of a master's degree of 45 hours or equivalent if the applicant entered a program of study prior to July 1, 2010, or verifying completion of a master's degree of 60 hours or equivalent if the applicant entered a program of study on or after July 1, 2010, or the appropriate doctoral degree. After March 31, 2009, graduates from a non-CACREP-accredited mental health counselor program or a non-COAMFTE-accredited marital and family therapy program shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site <http://cce-global.org>. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation;

5. Supplies satisfactory evidence of the candidate's qualifications in writing on the prescribed forms by the candidate's supervisors. If verification of clinical experience is not available, the board may consider submission of documentation from the state in which the applicant is currently licensed or equivalent documentation of supervision; and

6. Provides verification(s) of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- Licensee's name;
- Date of initial licensure;
- Current licensure status; and
- Any disciplinary action taken against the license.

7. In lieu of the requirements listed in paragraphs "3" through "5" of this rule, a mental health counselor applicant may provide to the board evidence that the applicant has demonstrated appropriate qualifications at either tier 1 or tier 2 of the National Credentials Registry of the American Association of State Counseling Boards. The mental health counselor applicant shall have the National Credentials Registry of the American Association of State Counseling Boards send directly to the board official verification that the applicant has met the qualifications.

[ARC 7673B, IAB 4/8/09, effective 4/30/09]

645—31.9(147) Licensure by reciprocal agreement. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.10(147) License renewal.

31.10(1) The biennial license renewal period for a license to practice marital and family therapy or mental health counseling shall begin on October 1 of an even-numbered year and end on September 30 of the next even-numbered year. The licensee is responsible for renewing the license prior to its expiration.

Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.10(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

31.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—32.2(272C) and the mandatory reporting requirements of subrule 31.10(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

31.10(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph "e."

Training may be completed through separate courses as identified in paragraphs "a" and "b" or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs "a" to "c," including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

f. The board may select licensees for audit of compliance with the requirements in paragraphs "a" to "e."

31.10(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. 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 or disciplinary investigation.

31.10(6) A person licensed to practice as a marital and family therapist or mental health counselor shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

31.10(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule

5.3(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice mental health counseling or marital and family therapy in Iowa until the license is reactivated. A licensee who practices mental health counseling or marital and family therapy in the state of Iowa with an inactive license 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, and other available legal remedies.

[ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—31.11(272C) Exemptions for inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—31.12(147) Licensee record keeping.

31.12(1) A licensee shall maintain sufficient, timely, and accurate documentation in client records.

31.12(2) For purposes of this rule, “client” means the individual, couple, family, or group to whom a licensee provides direct clinical services.

31.12(3) A licensee’s records shall reflect the services provided, facilitate the delivery of services, and ensure continuity of services in the future.

31.12(4) Clinical services. A licensee who provides clinical services in any employment setting, including private practice, shall:

a. Store records in accordance with state and federal statutes and regulations governing record retention and with the guidelines of the licensee’s employer or agency, if applicable. If no other legal provisions govern record retention, a licensee shall store all client records for a minimum of seven years after the date of the client’s discharge or death, or, in the case of a minor, for three years after the client reaches the age of majority under state law or seven years after the date of the client’s discharge or death, whichever is longer.

b. Maintain timely records that include subjective and objective data, an assessment, a treatment plan, and any revisions to the assessment or plan made during the course of treatment.

c. Provide the client with reasonable access to records concerning the client. A licensee who is concerned that a client’s access to the client’s records could cause serious misunderstanding or harm to the client shall provide assistance in interpreting the records and consultation with the client regarding the records. A licensee may limit a client’s access to the client’s records, or portions of the records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both the client’s request for access and the licensee’s rationale for withholding some or all of a record shall be documented in the client’s records.

d. Take steps to protect the confidentiality of other individuals identified or discussed in any records to which a client is provided access.

31.12(5) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, the licensee shall ensure that a duplicate hard-copy record or a backup, unalterable electronic record is maintained.

31.12(6) Correction of records.

a. Hard-copy records. Original notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the original record, it must be crossed out with a single, nondeleting line and be initialed and dated by the licensee.

b. Electronic records. If a record is stored in an electronic format, the record may be amended with a signed addendum attached to the record.

31.12(7) Confidentiality and transfer of records. Marital and family therapists or mental health counselors shall preserve the confidentiality of client records in accordance with their respective rules of conduct and with federal and state law. Upon receipt of a written release or authorization signed by the client, the licensee shall furnish such therapy records, or copies of the records, as will be beneficial for the future treatment of that client. A fee may be charged for duplication of records, but a licensee

may not refuse to transfer records for nonpayment of any fees. A written request may be required before transferring the record(s).

31.12(8) Retirement, death or discontinuance of practice.

a. If a licensee is retiring or discontinuing practice and is the owner of a practice, the licensee shall notify in writing all active clients and, upon knowledge and agreement of the clients, shall make reasonable arrangements with those clients to transfer client records, or copies of those records, to the succeeding licensee.

b. Upon a licensee's death:

(1) The licensee's employer or representative must ensure that all client records are transferred to another licensee or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The licensee's employer or representative shall notify each active client that the client's records will be transferred to another licensee or entity that will retain custody of the records and that, at the client's written request, the records will be sent to the licensee or entity of the client's choice.

31.12(9) Nothing stated in this rule shall prohibit a licensee from conveying or transferring the licensee's client records to another licensed individual who is assuming a practice, provided that written notice is furnished to all clients.

645—31.13(147) Duplicate certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.14(147) Reissued certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.15(17A,147,272C) License denial. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.16(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

31.16(1) Submit a reactivation application on a form provided by the board.

31.16(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

31.16(3) Provide verification of current competence to practice mental health counseling or marital and family therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 40 hours of continuing education within two years of the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 80 hours of continuing education within two years of application for reactivation.

645—31.17(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 31.16(17A,147,272C) prior to practicing mental health counseling or marital and family therapy in this state.

645—31.18(154D) Marital and family therapy and mental health counselor services subject to regulation. Marital and family therapy and mental health counselor services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the marital and family therapy and mental health counselor, shall constitute the practice of marital and family therapy and mental health counseling and shall be subject to regulation in Iowa.

These rules are intended to implement Iowa Code chapters 17A, 147, 154D and 272C.

[Filed 6/5/92, Notice 4/15/92—published 6/24/92, effective 7/29/92]

[Filed emergency 7/31/92—published 8/19/92, effective 7/31/92]

[Filed 11/17/94, Notice 9/14/94—published 12/7/94, effective 1/11/95]

[Filed 5/2/97, Notice 3/12/97—published 5/21/97, effective 6/25/97]

[Filed 5/16/97, Notice 4/9/97—published 6/4/97, effective 7/9/97]

[Filed 8/21/98, Notice 7/15/98—published 9/9/98, effective 10/14/98]

[Filed 4/2/99, Notice 2/10/99—published 4/21/99, effective 5/26/99]

[Filed 2/1/01, Notice 10/18/00—published 2/21/01, effective 3/28/01]

[Filed 12/6/01, Notice 10/3/01—published 12/26/01, effective 1/30/02]

[Filed 3/29/02, Notice 2/20/02—published 4/17/02, effective 5/22/02]

[Filed 9/26/02, Notice 7/24/02—published 10/16/02, effective 11/20/02]

[Filed 12/12/03, Notice 10/15/03—published 1/7/04, effective 2/11/04]

[Filed 6/15/05, Notice 4/13/05—published 7/6/05, effective 8/10/05][◇]

[Filed 12/9/05, Notice 10/12/05—published 1/4/06, effective 2/8/06]

[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]

[Filed 2/15/07, Notice 12/6/06—published 3/14/07, effective 4/18/07]

[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]¹

[Editorial change: IAC Supplement 2/25/09]

[Filed Emergency ARC 7673B, IAB 4/8/09, effective 4/30/09]

[Filed ARC 8152B (Notice ARC 7858B, IAB 6/17/09), IAB 9/23/09, effective 10/28/09]

[Filed ARC 9547B (Notice ARC 9416B, IAB 3/9/11), IAB 6/1/11, effective 7/6/11]

[◇] Two or more ARCs

¹ February 18, 2009, effective date of amendments to 645—31.4(154D) to 645—31.8(154D), **ARC 7476B**, Items 5 to 9, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 6, 2009.

CHAPTER 32
CONTINUING EDUCATION FOR MARITAL AND
FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

645—32.1(272C) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Active license*” means the license is current and has not expired.

“*Approved program/activity*” means a continuing education program/activity meeting the standards set forth in these rules.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the board of behavioral science.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of approved continuing education activity.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice marital and family therapy or mental health counseling in the state of Iowa.

645—32.2(272C) Continuing education requirements.

32.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on October 1 of the even-numbered year and ending on September 30 of the next even-numbered year. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 40 hours of continuing education approved by the board.

32.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 40 hours of continuing education per biennium for each subsequent license renewal.

32.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

32.2(4) No hours of continuing education shall be carried over into the next biennium except as stated for the second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

32.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

645—32.3(154D,272C) Standards.

32.3(1) General criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters.

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

- (1) Date(s), location, course title, presenter(s);
- (2) Number of program contact hours; and
- (3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

32.3(2) Specific criteria. Continuing education hours of credit may be obtained by completing the following:

a. Attendance at workshops, conferences, symposiums and academic courses. Official transcripts indicating successful completion of academic courses which apply to the field of mental health counseling or marital and family therapy, as appropriate, will be necessary in order to receive the following continuing education credits:

1 academic semester hour = 15 continuing education hours

1 academic quarter hour = 10 continuing education hours

b. Rescinded IAB 7/6/05, effective 8/10/05.

c. A maximum of 20 hours of continuing education credit may be granted for any of the following activities not to exceed a combined total of 20 hours:

(1) Presenting professional programs which meet the criteria in 645—32.3(272C). Two hours of credit will be awarded for each hour of presentation. A course schedule or brochure must be maintained for audit. Presentation at a professional program does not include teaching class at an institution of higher learning at which the applicant is regularly and primarily employed. Presentations to lay public are excluded.

(2) Scholarly research or other activities, the results of which are published in a recognized professional publication such as a refereed journal, monograph or conference proceedings. The scholarly research must be integrally related to the practice of the professions.

(3) Publication in a refereed journal. The article in a refereed journal for which the licensee is seeking continuing education credit must be integrally related to the practice of the professions.

(4) Distance learning conferences or courses will be allowed if the following criteria are met:

1. The program is offered through electronic transmission such as the Iowa Communications Network (ICN).

2. The program allows for interaction between the presenter and the participants.

3. The program issues the participants an official transcript, certificate of attendance or verification of successful completion of the course which applies to the field of mental health counseling or marital and family therapy.

(5) Home study courses will be allowed if the following criteria are met:

1. The program is recognized by the National Board for Certified Counselors (NBCC), Commission on Rehabilitation Counselor Certification (CRCC), American Association of Marriage and Family Therapy (AAMFT) or meets all of the criteria in 645—32.3(272C).

2. An official transcript, verification or certificate of completion is presented after successful completion of the course.

(6) Viewing multimedia presentations will be allowed if the following criteria are met:

1. There is a sponsoring group or agency.

2. There is a facilitator or program official present.

3. The program official may not be the only attendee.

4. The program meets all of the criteria in 645—32.3(272C).

(7) Computer-assisted instructional courses or programs pertaining to the practice of mental health counseling or marital and family therapy will be allowed if the following criteria are met:

1. The courses and programs are approved by the National Board for Certified Counselors (NBCC), Commission on Rehabilitation Counselor Certification (CRCC), American Association of Marriage and Family Therapy (AAMFT) or their affiliates or meet all of the criteria in 645—32.3(272C).

2. An official transcript, certificate of completion, or verification that includes the following information is presented after successful completion of the course:

- Date course/program was completed.

- Title of the course/program.
- Number of course/program continuing education hours.
- Official signature or verification of the course/program sponsor.

(8) Teaching in an approved college, university, or graduate school. The licensee may receive credit on a one-time basis for the first offering of the course.

(9) Authoring papers, publications, and books. The licensee shall receive five hours of credit per page with a maximum of 20 hours of credit.

32.3(3) Required specific criteria. Three hours of the 40 continuing education hours shall be in ethics.

645—32.4(154D,272C) Audit of continuing education report. Rescinded IAB 6/1/11, effective 7/6/11.

645—32.5(154D,272C) Automatic exemption. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.6(154D,272C) Grounds for disciplinary action. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.7(272C) Continuing education waiver for active practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.8(272C) Continuing education exemption for inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.9(154D,272C) Continuing education exemption for disability or illness. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.10(272C) Reinstatement of inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.11(272C) Hearings. Rescinded IAB 7/6/05, effective 8/10/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 154D.

[Filed 2/1/01, Notice 10/18/00—published 2/21/01, effective 3/28/01]

[Filed 12/6/01, Notice 10/3/01—published 12/26/01, effective 1/30/02]

[Filed 6/15/05, Notice 4/13/05—published 7/6/05, effective 8/10/05]

[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

[Filed ARC 9547B (Notice ARC 9416B, IAB 3/9/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 33
DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS
AND MENTAL HEALTH COUNSELORS

[Prior to 1/30/02, see 645—Chapter 31]

645—33.1(154D) Definitions.

“*Board*” means the board of behavioral science.

“*Discipline*” means any sanction the board may impose upon licensees.

“*Licensee*” means a person licensed to practice as a marital and family therapist or mental health counselor in Iowa.

645—33.2(154D,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—33.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

33.2(1) Failure to comply with the national association’s code of ethics.

a. Marital and family therapists. Failure to comply with the current American Association for Marriage and Family Therapy (AAMFT) Code of Ethics, which is hereby adopted by reference. Copies of the Code of Ethics may be obtained from the AAMFT’s Web site.

b. Mental health counselors. Failure to comply with the current Code of Ethics of the American Counseling Association (ACA), which is hereby adopted by reference. Copies of the Code of Ethics may be obtained from the ACA Web site.

33.2(2) 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 in this state, which includes the following:

a. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or

b. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

33.2(3) Professional incompetency. Professional incompetency includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of the licensed marital and family therapist or mental health counselor in this state.

e. Mental or physical inability reasonably related to and adversely affecting the licensee’s ability to practice in a safe and competent manner.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

33.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

33.2(5) Practice outside the scope of the profession.

33.2(6) 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 information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

33.2(7) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee's ability to practice with reasonable skill or safety.

33.2(8) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

33.2(9) Falsification of client records.

33.2(10) Acceptance of any fee by fraud or misrepresentation.

33.2(11) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

33.2(12) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

33.2(13) Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession.

33.2(14) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory, or country; or failure by the licensee to report in writing to the board revocation, suspension, or other disciplinary action taken by a licensing authority within 30 days of the final action. 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.

33.2(15) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the practice of the profession in another state, district, territory or country.

33.2(16) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

33.2(17) Failure to notify the board within 30 days after the occurrence of any judgment or settlement of a malpractice claim or action.

33.2(18) Engaging in any conduct that subverts or attempts to subvert a board investigation.

33.2(19) Failure to comply with a subpoena issued by the board, or to otherwise fail to cooperate with an investigation of the board.

33.2(20) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

33.2(21) Failure to pay costs assessed in any disciplinary action.

33.2(22) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

33.2(23) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

33.2(24) Knowingly aiding, assisting, procuring, or advising a person to unlawfully practice as a marital and family therapist or a mental health counselor.

33.2(25) Failure to report a change of name or address within 30 days after it occurs.

33.2(26) Representing oneself as a licensed marital and family therapist or mental health counselor when one's license has been suspended or revoked, or when one's license is on inactive status.

33.2(27) Permitting another person to use the licensee's license for any purpose.

33.2(28) Permitting an unlicensed employee or person under the licensee's control to perform activities requiring a license.

33.2(29) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but need not be limited to, the following:

a. Verbally or physically abusing a patient, client or coworker.

b. Improper sexual contact with, or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.

c. Betrayal of a professional confidence.

d. Engaging in a professional conflict of interest.

33.2(30) Sexual relationships.

a. Current clients. A licensee shall not engage in sexual activities or sexual contact with a client, regardless of whether such contact is consensual or nonconsensual.

b. Former clients. A licensee shall not engage in sexual activities or sexual contact with a former client within the five years following termination of the client relationship. A licensee shall not engage in sexual activities or sexual contact with a former client, regardless of the length of time elapsed since termination of the client relationship, if the client has a history of physical, emotional, or sexual abuse or if the client has ever been diagnosed with any form of psychosis or personality disorder or if the client is likely to remain in need of therapy due to the intensity or chronicity of a problem.

c. A licensee shall not engage in sexual activities or sexual contact with a client's or former client's spouse or significant other.

d. A licensee shall not engage in sexual activities or sexual contact with a client's or former client's relative within the second degree of consanguinity (client's parent, grandparent, child, grandchild, or sibling) when there is a risk of exploitation or potential harm to a client or former client.

e. A licensee shall not provide clinical services to an individual with whom the licensee has had prior sexual contact.

33.2(31) Physical contact. A licensee shall not engage in physical contact with a client when there is a possibility of psychological harm to the client as a result of the contact. A licensee who engages in appropriate physical contact with a client is responsible for setting clear, appropriate, and culturally and age-sensitive boundaries which govern such contact.

33.2(32) Failure to comply with universal precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control of the United States Department of Health and Human Services.

33.2(33) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[ARC 9547B, IAB 6/1/11, effective 7/6/11]

645—33.3(147,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed \$1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—33.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care to the citizens of this state;
2. The facts of the particular violation;

3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—33.5(154D) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 1/14/09, effective 2/18/09.

These rules are intended to implement Iowa Code chapters 17A, 147, 154D and 272C.

[Filed emergency 9/24/93—published 10/13/93, effective 9/24/93]

[Filed 2/11/94, Notice 10/13/93—published 3/2/94, effective 4/7/94]

[Filed 11/17/94, Notice 9/14/94—published 12/7/94, effective 1/11/95]

[Filed 8/21/98, Notice 7/15/98—published 9/9/98, effective 10/14/98]

[Filed 4/2/99, Notice 2/10/99—published 4/21/99, effective 5/26/99]

[Filed 5/28/99, Notice 4/7/99—published 6/16/99, effective 7/21/99]

[Filed 2/1/01, Notice 10/18/00—published 2/21/01, effective 3/28/01]

[Filed 12/6/01, Notice 10/3/01—published 12/26/01, effective 1/30/02]

[Filed 12/12/03, Notice 10/15/03—published 1/7/04, effective 2/11/04]

[Filed 6/15/05, Notice 4/13/05—published 7/6/05, effective 8/10/05]

[Filed 12/9/05, Notice 10/12/05—published 1/4/06, effective 2/8/06]

[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]

[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

[Filed ARC 9547B (Notice ARC 9416B, IAB 3/9/11), IAB 6/1/11, effective 7/6/11]

CHAPTER 8
UNIVERSAL PRACTICE STANDARDS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 6]

657—8.1(155A) Purpose and scope. The requirements of these rules apply to all Iowa-licensed pharmacists and to all pharmacies providing the services addressed in this chapter to patients in Iowa and are in addition to rules of the board relating to specific types of pharmacy licenses issued by the board.

657—8.2(155A) Pharmaceutical care. Pharmaceutical care is a comprehensive, patient-centered, outcomes-oriented pharmacy practice in which the pharmacist accepts responsibility for assisting the prescriber and the patient in optimizing the patient's drug therapy plan and works to promote health, to prevent disease, and to optimize drug therapy. Pharmaceutical care does not include the prescribing of drugs without the consent of the prescribing practitioner.

8.2(1) Drug therapy problems. In providing pharmaceutical care, the pharmacist shall strive to identify, resolve, and prevent drug therapy problems.

8.2(2) Drug therapy plan. In providing pharmaceutical care, the pharmacist shall access and evaluate patient-specific information, identify drug therapy problems, and utilize that information in a documented plan of therapy that assists the patient or the patient's caregiver in achieving optimal drug therapy. In concert with the patient, the patient's prescribing practitioner, and the patient's other health care providers, the pharmacist shall assess, monitor, and suggest modifications of the plan as appropriate.

8.2(3) Eligibility. Any Iowa-licensed pharmacist may practice pharmaceutical care.

657—8.3(155A) Responsibility.

8.3(1) Pharmacy operations. The pharmacy and the pharmacist in charge share responsibility for ensuring that all operations of the pharmacy are in compliance with federal and state laws, rules, and regulations relating to pharmacy operations and the practice of pharmacy.

8.3(2) Practice functions. The pharmacist is responsible for all functions performed in the practice of pharmacy. The pharmacist maintains responsibility for any and all delegated functions including functions delegated to pharmacist-interns, pharmacy technicians, and pharmacy support persons.

8.3(3) Pharmacist-documented verification. The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—8.4(155A) Pharmacist identification and staff logs.

8.4(1) Display of pharmacist license. During any period the pharmacist is working in a pharmacy, each pharmacist shall display, in a position visible to the public, an original license to practice pharmacy. A current license renewal certificate, which may be a photocopy of an original renewal certificate, shall be displayed with the original license.

8.4(2) Identification codes. A permanent log of the initials or identification codes identifying by name each dispensing pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person shall be maintained for a minimum of two years and shall be available for inspection and copying by the board or its representative. The initials or identification code shall be unique to the individual to ensure that each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person can be identified.

8.4(3) Temporary or intermittent pharmacy staff. The pharmacy shall maintain a log of all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons who have worked at that pharmacy and who are not regularly staffed at that pharmacy. Such log shall include the dates and shifts worked by each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person and shall be available for inspection and copying by the board or its representative for a minimum of two years following the date of the entry.

8.4(4) Identification badge. A pharmacist shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacist and includes at least the pharmacist's first name.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9409B, IAB 3/9/11, effective 4/13/11]

657—8.5(155A) Environment and equipment requirements. There shall be adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy. Space and equipment in an amount and type to provide secure, environmentally controlled storage of drugs shall be available.

8.5(1) Refrigeration. The pharmacy shall maintain one or more refrigeration units. The temperature of the refrigerator shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration, and a thermometer shall be maintained in the refrigerator to verify the temperature.

8.5(2) Sink. The pharmacy shall have a sink with hot and cold running water located within the pharmacy department and available to all pharmacy personnel; the sink shall be maintained in a sanitary condition.

8.5(3) Secure barrier. The pharmacy department shall be surrounded by a physical barrier capable of being securely locked to prevent entry when the department is closed. A secure barrier may be constructed of other than a solid material with a continuous surface if the openings in the material are not large enough to permit removal of items from the pharmacy department by any means. Any material used in the construction of the barrier shall be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The plans and specifications of the barrier shall be submitted to the board for approval prior to the start of construction. The board may also require on-site inspection of the facility or pharmacy department prior to the pharmacy's opening or relocation. The pharmacy department shall be closed and secured in the absence of the pharmacist except as provided in rule 657—6.7(124,155A) or 657—7.6(124,155A).

8.5(4) Orderly and clean. The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be in good operating condition and maintained in a sanitary manner. Animals shall not be allowed within a licensed pharmacy unless that pharmacy is exclusively providing services for the treatment of animals or unless the animal is a service dog or assistive animal as defined in Iowa Code subsection 216C.11(1).

8.5(5) Light and ventilation. The pharmacy shall be properly lighted and ventilated.

8.5(6) Temperature and humidity. The temperature and humidity of the pharmacy shall be maintained within a range compatible with the proper storage of drugs.

8.5(7) Other equipment. The pharmacist in charge shall ensure the availability of any other equipment necessary for the particular practice of pharmacy and to meet the needs of the patients served by the pharmacy.

8.5(8) Bulk counting machines. Unless bar-code scanning is required and utilized to verify the identity of each stock container of drugs utilized to restock a counting machine cell or bin, a pharmacist shall verify the accuracy of the drugs to be restocked prior to filling the counting machine cell or bin. A record identifying the individual who verified the drugs to be restocked, the individual who restocked the counting machine cell or bin, and the date shall be maintained. The pharmacy shall have a method to calibrate and verify the accuracy of the counting device and shall, at least quarterly, verify the accuracy of the device and maintain a dated record identifying the individual who performed the quarterly verification.

[ARC 8671B, IAB 4/7/10, effective 5/12/10]

657—8.6(155A) Health of personnel. Only personnel authorized by the responsible pharmacist shall be in the immediate vicinity of the drug dispensing, preparation, compounding, or storage areas. Any person shown, either by medical examination or pharmacist determination, to have an apparent illness or open lesions that may adversely affect the quality or safety of a drug product or another individual shall be excluded from direct contact with components, bulk drug substances, drug product containers, closures, in-process materials, drug products, and patients until the condition is corrected or determined by competent medical personnel not to jeopardize the quality or safety of drug products or patients. All

personnel who normally assist the pharmacist shall be instructed to report to the pharmacist any health conditions that may have an adverse effect on drug products or may pose a health or safety risk to others.

657—8.7(155A) Procurement, storage, and recall of drugs and devices.

8.7(1) Source. Procurement of prescription drugs and devices shall be from a drug wholesaler licensed by the board to distribute to Iowa pharmacies or, on a limited basis, from another licensed pharmacy or licensed practitioner located in the United States.

8.7(2) Sufficient stock. A pharmacy shall maintain sufficient stock of drugs and devices to fulfill the foreseeable needs of the patients served by the pharmacy.

8.7(3) Manner of storage. Drugs and devices shall be stored in a manner to protect their identity and integrity.

8.7(4) Storage temperatures. All drugs and devices shall be stored at the proper temperature, as defined by the following terms:

a. “Controlled room temperature” means temperature maintained thermostatically between 15 degrees and 30 degrees Celsius (59 degrees and 86 degrees Fahrenheit);

b. “Cool” means temperature between 8 degrees and 15 degrees Celsius (46 degrees and 59 degrees Fahrenheit). Drugs and devices may be stored in a refrigerator unless otherwise specified on the labeling;

c. “Refrigerate” means temperature maintained thermostatically between 2 degrees and 8 degrees Celsius (36 degrees and 46 degrees Fahrenheit); and

d. “Freeze” means temperature maintained thermostatically between -20 degrees and -10 degrees Celsius (-4 degrees and 14 degrees Fahrenheit).

8.7(5) Product recall. There shall be a system for removing from use, including unit dose, any drugs and devices subjected to a product recall.

657—8.8(124,155A) Out-of-date drugs or devices. Any drug or device bearing an expiration date shall not be dispensed for use beyond the expiration date of the drug or device. Outdated drugs or devices shall be removed from dispensing stock and shall be quarantined until such drugs or devices are properly disposed of.

657—8.9(124,155A) Records. Every inventory or other record required to be maintained by a pharmacy pursuant to board rules or Iowa Code chapters 124 and 155A shall be maintained and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular record or inventory. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department. The following records shall be maintained for at least two years.

8.9(1) Drug supplier invoices. All pharmacies shall maintain supplier invoices of prescription drugs and controlled substances upon which the actual date of receipt of the controlled substances by the pharmacist or other responsible individual is clearly recorded.

8.9(2) Drug supplier credits. All pharmacies shall maintain supplier credit memos for controlled substances and prescription drugs.

[ARC 8539B, IAB 2/24/10, effective 4/1/10]

657—8.10 Reserved.

657—8.11(147,155A) Unethical conduct or practice. The provisions of this rule apply to licensed pharmacies, licensed pharmacists, registered pharmacy technicians, registered pharmacy support persons, and registered pharmacist-interns.

8.11(1) Misrepresentative deeds. A pharmacist, technician, support person, or pharmacist-intern shall not make any statement intended to deceive, misrepresent or mislead anyone, or be a party to or

an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

8.11(2) *Undue influence.*

a. A pharmacist shall not accept professional employment or share or receive compensation in any form arising out of, or incidental to, the pharmacist's professional activities from a prescriber of prescription drugs or any other person or corporation in which one or more such prescribers have a proprietary or beneficial interest sufficient to permit them to directly or indirectly exercise supervision or control over the pharmacist in the pharmacist's professional responsibilities and duties or over the pharmacy wherein the pharmacist practices.

b. A prescriber may employ a pharmacist to provide nondispensing, drug information, or other cognitive services.

8.11(3) *Lease agreements.* A pharmacist shall not lease space for a pharmacy under any of the following conditions:

a. From a prescriber of prescription drugs or a group, corporation, association, or organization of such prescribers on a percentage of income basis;

b. From a group, corporation, association, or organization in which prescribers have majority control or have directly or indirectly a majority beneficial or proprietary interest on a percentage of income basis; or

c. If the rent is not reasonable according to commonly accepted standards of the community in which the pharmacy will be located.

8.11(4) *Nonconformance with law.* A pharmacist, technician, support person, or pharmacist-intern shall not knowingly serve in a pharmacy which is not operated in conformance with law, or which engages in any practice which if engaged in by a pharmacist would be unethical conduct.

8.11(5) *Freedom of choice/solicitation/kickbacks/fee-splitting and imprinted prescription blanks or forms.* A pharmacist or pharmacy shall not enter into any agreement which negates a patient's freedom of choice of pharmacy services. A purchasing pharmacist or pharmacy shall not engage in any activity or include in any agreement with a selling pharmacist or pharmacy any provision that would prevent or prohibit the prior notifications required in subrule 8.35(7). A pharmacist or pharmacy shall not participate in prohibited agreements with any person in exchange for recommending, promoting, accepting, or promising to accept the professional pharmaceutical services of any pharmacist or pharmacy. "Person" includes an individual, corporation, partnership, association, firm, or other entity. "Prohibited agreements" includes an agreement or arrangement that provides premiums, "kickbacks," fee-splitting, or special charges as compensation or inducement for placement of business or solicitation of patronage with any pharmacist or pharmacy. "Kickbacks" includes, but is not limited to, the provision of medication carts, facsimile machines, any other equipment, or preprinted forms or supplies for the exclusive use of a facility or practitioner at no charge or billed below reasonable market rate. A pharmacist shall not provide, cause to be provided, or offer to provide to any person authorized to prescribe prescription blanks or forms bearing the pharmacist's or pharmacy's name, address, or other means of identification, except that a hospital may make available to hospital staff prescribers, emergency department prescribers, and prescribers granted hospital privileges for the prescribers' use during practice at or in the hospital generic prescription blanks or forms bearing the name, address, or telephone number of the hospital pharmacy.

8.11(6) *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

8.11(7) *Claims of professional superiority.* A pharmacist shall not make a claim, assertion, or inference of professional superiority in the practice of pharmacy which cannot be substantiated, or claim an unusual, unsubstantiated capacity to supply a drug or professional service to the community.

8.11(8) *Unprofessional conduct or behavior.* A pharmacist shall not exhibit unprofessional behavior in connection with the practice of pharmacy or refuse to provide reasonable information or answer reasonable questions for the benefit of the patient. Unprofessional behavior shall include, but not be

limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

[ARC 9526B, IAB 6/1/11, effective 7/6/11]

657—8.12(126,147) Advertising. Prescription drug price and nonprice information may be provided to the public by a pharmacy so long as the information is not false or misleading and is not in violation of any federal or state laws applicable to the advertisement of such articles generally and if all of the following conditions are met:

1. All charges for services to the consumer must be stated.
2. The effective dates for the prices listed shall be stated.
3. No reference shall be made to controlled substances listed in Schedules II through V of the latest revision of the Iowa uniform controlled substances Act and the rules of the Iowa board of pharmacy.

657—8.13(135C,155A) Personnel histories. Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this rule shall apply to any pharmacy employing any person to provide patient care services in a patient's home. For the purposes of this rule, "employed by the pharmacy" shall include any individual who is paid to provide treatment or services to any patient in the patient's home, whether the individual is paid by the pharmacy or by any other entity such as a corporation, a temporary staffing agency, or an independent contractor. Specifically excluded from the requirements of this rule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or drug being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or drug used to treat the patient in the patient's home.

8.13(1) Applicant acknowledgment. The pharmacy shall ask the following question of each person seeking employment in a position that will provide in-home services: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

8.13(2) Criminal history check. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of public safety a form specified by the department of public safety and receive the results of a criminal history check.

8.13(3) Abuse history checks. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of human services a form specified by the department of human services and receive the results of a dependent adult abuse record check. The pharmacy may submit to the department of human services a form specified by the department of human services to request a child abuse history check.

a. A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report, has concluded that the crime or founded abuse does not merit prohibition from such employment, and has notified the pharmacy that the person may be employed to provide in-home services.

b. The pharmacy shall keep copies of all record checks and evaluations for a minimum of two years following receipt of the record or for a minimum of two years after the individual is no longer employed by the pharmacy, whichever is greater.

657—8.14(155A) Training and utilization of pharmacy technicians or pharmacy support persons. All Iowa-licensed pharmacies utilizing pharmacy technicians or pharmacy support persons shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Pharmacy policies shall specify the frequency of review. Pharmacy technician and pharmacy support person training shall be documented and maintained by the pharmacy

for the duration of employment. Policies and procedures and documentation of pharmacy technician and pharmacy support person training shall be available for inspection by the board or an agent of the board.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—8.15(155A) Delivery of prescription drugs and devices. Prescription drug orders, prescription devices, and completed prescription drug containers may be delivered, in compliance with all laws, rules, and regulations relating to the practice of pharmacy, to patients at any place of business licensed as a pharmacy.

8.15(1) Alternative methods. A licensed pharmacy may, by means of its employee or by use of a common carrier, pick up or deliver prescriptions to the patient or the patient's caregiver as follows:

- a. At the office or home of the prescriber.
- b. At the residence of the patient or caregiver.
- c. At the hospital or medical care facility in which a patient is confined.
- d. At an outpatient medical care facility where the patient receives treatment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the outpatient medical care facility;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, or an authorized agent identified in the written authorization;

(3) A prescription authorized by a prescriber not treating the patient at the outpatient medical care facility may be transmitted to the pharmacy by the authorized agent via facsimile provided that the means of transmission does not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the prescription and provided that the original written prescription is delivered to the pharmacy prior to delivery of the filled prescription to the patient; and

(4) The outpatient medical care facility shall store the patient's filled prescriptions in a secure area pending delivery to the patient.

e. At the patient's or caregiver's place of employment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the place of employment;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, the prescriber, or an authorized agent identified in the written authorization; and

(3) The pharmacy shall ensure the security of confidential information as defined in subrule 8.16(1).

8.15(2) Policies and procedures required. Every pharmacy shipping or otherwise delivering prescription drugs or devices to Iowa patients shall develop and implement policies and procedures to ensure accountability, safe delivery, and compliance with temperature requirements as defined by subrule 8.7(4).

[ARC 7636B, IAB 3/11/09, effective 4/15/09]

657—8.16(124,155A) Confidential information.

8.16(1) Definition. "Confidential information" means information accessed or maintained by the pharmacy in the patient's records which contains personally identifiable information that could be used to identify the patient. This includes but is not limited to patient name, address, telephone number, and social security number; prescriber name and address; and prescription and drug or device information such as therapeutic effect, diagnosis, allergies, disease state, pharmaceutical services rendered, medical information, and drug interactions, regardless of whether such information is communicated to or from the patient, is in the form of paper, is preserved on microfilm, or is stored on electronic media.

8.16(2) Release of confidential information. Confidential information in the patient record may be released only as follows:

- a. Pursuant to the express written authorization of the patient or the order or direction of a court.
- b. To the patient or the patient's authorized representative.
- c. To the prescriber or other licensed practitioner then caring for the patient.
- d. To another licensed pharmacist when the best interests of the patient require such release.

e. To the board or its representative or to such other persons or governmental agencies duly authorized by law to receive such information.

A pharmacist shall utilize the resources available to determine, in the professional judgment of the pharmacist, that any persons requesting confidential patient information pursuant to this rule are entitled to receive that information.

8.16(3) Exceptions. Nothing in this rule shall prohibit pharmacists from releasing confidential patient information as follows:

a. Transferring a prescription to another pharmacy upon the request of the patient or the patient's authorized representative.

b. Providing a copy of a nonrefillable prescription to the person for whom the prescription was issued which is clearly marked as a copy and not to be filled.

c. Providing drug therapy information to physicians or other authorized prescribers for their patients.

d. Disclosing information necessary for the processing of claims for payment of health care operations or services.

e. Transferring, subject to the provisions of subrule 8.35(7), prescription and patient records of a pharmacy that discontinues operation as a pharmacy to another licensed pharmacy that is held to the same standards of confidentiality and that agrees to act as custodian of the transferred records.

8.16(4) System security and safeguards. To maintain the integrity and confidentiality of patient records and prescription drug orders, any system or computer utilized shall have adequate security including system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of patient records and prescription drug orders.

8.16(5) Record disposal. Disposal of any materials containing or including patient-specific or confidential information shall be conducted in a manner to preserve patient confidentiality.

[ARC 9526B, IAB 6/1/11, effective 7/6/11]

657—8.17 and 8.18 Reserved.

657—8.19(124,126,155A) Manner of issuance of a prescription drug or medication order. A prescription drug order or medication order may be transmitted from a prescriber to a pharmacy in written form, orally including telephone voice communication, or by electronic transmission in accordance with applicable federal and state laws and rules. Any prescription drug order or medication order provided to a patient in written or printed form shall include the original, handwritten signature of the prescriber except as provided in rule 657—21.7(124,155A).

8.19(1) Verification. The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of any prescription drug order or medication order consistent with federal and state laws and rules. In exercising professional judgment, the prescribing practitioner and the pharmacist shall take adequate measures to guard against the diversion of prescription drugs and controlled substances through prescription forgeries.

8.19(2) Transmitting agent. The prescribing practitioner may authorize an agent to transmit to the pharmacy a prescription drug order or medication order orally or by electronic transmission provided that the name of the transmitting agent is included in the order.

a. New order. A new written or electronically prepared and transmitted prescription drug or medication order shall be manually or electronically signed by the prescriber. If transmitted by the prescriber's agent, the name and title of the transmitting agent shall be included in the order.

b. Refill order or renewal order. An authorization to refill a prescription drug or medication order, or to renew or continue an existing drug therapy, may be transmitted to a pharmacist through oral communication, in writing, or by electronic transmission initiated by or directed by the prescriber.

(1) If the transmission is completed by the prescriber's agent and the name and title of the transmitting agent is included in the order, the prescriber's signature is not required on the fax or alternate electronic transmission.

(2) If the order differs in any manner from the original order, such as a change of the drug strength, dosage form, or directions for use, the prescriber shall sign the order as provided by paragraph “a.”

8.19(3) Receiving agent. Regardless of the means of transmission to a pharmacy, only a pharmacist, a pharmacist-intern, or a pharmacy technician shall be authorized to receive a prescription drug or medication order from a practitioner or the practitioner’s agent.

8.19(4) Legitimate purpose. The pharmacist shall ensure that the prescription drug or medication order, regardless of the means of transmission, has been issued for a legitimate medical purpose by an authorized practitioner acting in the usual course of the practitioner’s professional practice. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire, an Internet-based consultation, or a telephonic consultation and without a valid preexisting patient-practitioner relationship.

8.19(5) Refills. A prescription for a prescription drug or device that is not a controlled substance may authorize no more than 12 refills within 18 months following the date on which the prescription is issued. A refill is one or more dispensings of a prescription drug or device that results in the patient’s receipt of the quantity authorized by the prescriber for a single fill as indicated on the prescription drug order.

[ARC 8171B, IAB 9/23/09, effective 10/28/09]

657—8.20(155A) Valid prescriber/patient relationship. Prescription drug orders and medication orders shall be valid as long as a prescriber/patient relationship exists. Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or oversee the patient’s use of a prescription drug, the order loses its validity and the pharmacist, on becoming aware of the situation, shall cancel the order and any remaining refills. The pharmacist shall, however, exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the prescribed drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new order can be issued.

657—8.21(155A) Prospective drug use review. For purposes of promoting therapeutic appropriateness and ensuring rational drug therapy, a pharmacist shall review the patient record, information obtained from the patient, and each prescription drug or medication order to identify:

1. Overutilization or underutilization;
2. Therapeutic duplication;
3. Drug-disease contraindications;
4. Drug-drug interactions;
5. Incorrect drug dosage or duration of drug treatment;
6. Drug-allergy interactions;
7. Clinical abuse/misuse;
8. Drug-prescriber contraindications.

Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem and shall, if necessary, include consultation with the prescriber. The review and assessment of patient records shall not be delegated to staff assistants but may be delegated to registered pharmacist-interns under the direct supervision of the pharmacist.

657—8.22 to 8.25 Reserved.

657—8.26(155A) Continuous quality improvement program. Each pharmacy licensed to provide pharmaceutical services to patients in Iowa shall implement or participate in a continuous quality improvement program or CQI program. The CQI program is intended to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate, and prevent medication errors, thereby improving medication therapy and the quality of patient care. A pharmacy that participates as an active member of a hospital or corporate CQI program that meets the objectives of this rule shall not be required to implement a new program pursuant to this rule.

8.26(1) Reportable program events. For purposes of this rule, a reportable program event or program event means a preventable medication error resulting in the incorrect dispensing of a prescribed drug received by or administered to the patient and includes but is not necessarily limited to:

- a. An incorrect drug;
- b. An incorrect drug strength;
- c. An incorrect dosage form;
- d. A drug received by the wrong patient;
- e. Inadequate or incorrect packaging, labeling, or directions; or
- f. Any incident related to a prescription dispensed to a patient that results in or has the potential to result in serious harm to the patient.

8.26(2) Responsibility. The pharmacist in charge is responsible for ensuring that the pharmacy utilizes a CQI program consistent with the requirements of this rule. The pharmacist in charge may delegate program administration and monitoring, but the pharmacist in charge maintains ultimate responsibility for the validity and consistency of program activities.

8.26(3) Policies and procedures. Each pharmacy shall develop, implement, and adhere to written policies and procedures for the operation and management of the pharmacy's CQI program. A copy of the pharmacy's CQI program description and policies and procedures shall be maintained and readily available to all pharmacy personnel. The policies and procedures shall address, at a minimum, a planned process to:

- a. Train all pharmacy personnel in relevant phases of the CQI program;
- b. Identify and document reportable program events;
- c. Minimize the impact of reportable program events on patients;
- d. Analyze data collected to assess the causes and any contributing factors relating to reportable program events;
- e. Use the findings to formulate an appropriate response and to develop pharmacy systems and workflow processes designed to prevent and reduce reportable program events; and
- f. Periodically, but at least annually, meet with appropriate pharmacy personnel to review findings and inform personnel of changes that have been made to pharmacy policies, procedures, systems, or processes as a result of CQI program findings.

8.26(4) Event discovery and notification. As provided by the procedures of the CQI program, the pharmacist in charge or appropriate designee shall be informed of and review all reported and documented program events. All pharmacy personnel shall be trained to immediately inform the pharmacist on duty of any discovered or suspected program event. When the pharmacist on duty determines that a reportable program event has occurred, the pharmacist shall ensure that all reasonably necessary steps are taken to remedy any problems or potential problems for the patient and that those steps are documented. Necessary steps include, but are not limited to, the following:

- a. Notifying the patient or the patient's caregiver and the prescriber or other members of the patient's health care team as warranted;
- b. Identifying and communicating directions or processes for correcting the error; and
- c. Communicating instructions for minimizing any negative impact on the patient.

8.26(5) CQI program records. All CQI program records shall be maintained on site at the pharmacy or shall be accessible at the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the record. When a reportable program event occurs or is suspected to have occurred, the program event shall be documented in a written or electronic storage record created solely for that purpose. Records of program events shall be maintained in an orderly manner and shall be filed chronologically by date of discovery.

a. The program event shall initially be documented as soon as practicable by the staff member who discovers the event or is informed of the event.

b. Program event documentation shall include a description of the event that provides sufficient information to permit categorization and analysis of the event and shall include:

- (1) The date and time the program event was discovered and the name of the staff person who discovered the event; and

(2) The names of the individuals recording and reviewing or analyzing the program event information.

8.26(6) Program event analysis and response. The pharmacist in charge or designee shall review each reportable program event and determine if follow-up is necessary. When appropriate, information and data collected and documented shall be analyzed, individually and collectively, to assess the cause and any factors contributing to the program event. The analysis may include, but is not limited to, the following:

a. A consideration of the effects on the quality of the pharmacy system related to workflow processes, technology utilization and support, personnel training, and both professional and technical staffing levels;

b. Any recommendations for remedial changes to pharmacy policies, procedures, systems, or processes; and

c. The development of a set of indicators that a pharmacy will utilize to measure its program standards over a designated period of time.

657—8.27 to 8.29 Reserved.

657—8.30(126,155A) Sterile products. Rescinded IAB 6/6/07, effective 7/11/07.

657—8.31 Reserved.

657—8.32(124,155A) Individuals qualified to administer. The board designates the following as qualified individuals to whom a practitioner may delegate the administration of prescription drugs. Any person specifically authorized under pertinent sections of the Iowa Code to administer prescription drugs shall construe nothing in this rule to limit that authority.

1. Persons who have successfully completed a medication administration course.
2. Licensed pharmacists.

657—8.33(147,155A) Supervision of pharmacists who administer adult immunizations. A physician may prescribe via written protocol adult immunizations for influenza and pneumococcal vaccines for administration by an authorized pharmacist if the physician meets these requirements for supervising the pharmacist.

8.33(1) Definitions.

a. “Authorized pharmacist” means an Iowa-licensed pharmacist who has documented that the pharmacist has successfully completed an organized course of study in a college or school of pharmacy or an Accreditation Council for Pharmacy Education (ACPE)-approved continuing pharmaceutical education program on vaccine administration that:

(1) Requires documentation by the pharmacist of current certification in the American Heart Association or the Red Cross Basic Cardiac Life Support Protocol for health care providers;

(2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current Centers for Disease Control and Prevention guidelines, and provides instruction and experiential training in the following content areas:

1. Standards for immunization practices;
2. Basic immunology and vaccine protection;
3. Vaccine-preventable diseases;
4. Recommended immunization schedules;
5. Vaccine storage and management;
6. Informed consent;
7. Physiology and techniques for vaccine administration;
8. Pre- and post-vaccine assessment and counseling;
9. Immunization record management; and

10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. "Vaccine" means a specially prepared antigen which, upon administration to a person, will result in immunity and, specifically for the purposes of this rule, shall mean influenza and pneumococcal vaccines.

c. "Written protocol" means a physician's order for one or more patients that contains, at a minimum, the following:

(1) A statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of administration of adult immunizations for influenza and pneumococcus;

(2) A statement identifying the individual authorized pharmacist;

(3) A statement that forbids an authorized pharmacist from delegating the administration of adult immunizations to anyone other than another authorized pharmacist, a registered pharmacist-intern under the direct personal supervision of the authorized pharmacist, or a registered nurse;

(4) A statement identifying the vaccines that may be administered by an authorized pharmacist, the dosages, and the route of administration;

(5) A statement identifying the activities an authorized pharmacist shall follow in the course of administering adult immunizations, including:

1. Procedures for determining if a patient is eligible to receive the vaccine;

2. Procedures for determining the appropriate scheduling and frequency of drug administration in accordance with applicable guidelines;

3. Procedures for record keeping and long-term record storage including batch or identification numbers;

4. Procedures to follow in case of life-threatening reactions; and

5. Procedures for the pharmacist and patient to follow in case of reactions following administration.

(6) A statement that describes how the authorized pharmacist shall report the administration of adult immunizations, within 30 days, to the physician issuing the written protocols and to the patient's primary care physician if one has been designated by the patient. In case of serious complications, the authorized pharmacist shall notify the physicians within 24 hours and submit a VAERS report to the bureau of immunizations, Iowa department of public health. (VAERS is the Vaccine Advisory Event Reporting System.) A serious complication is one that requires further medical or therapeutic intervention to effectively protect the patient from further risk, morbidity, or mortality.

8.33(2) *Supervision.* A physician who prescribes adult immunizations to an authorized pharmacist for administration shall adequately supervise that pharmacist. Physician supervision shall be considered adequate if the delegating physician:

a. Ensures that the authorized pharmacist is prepared as described in subrule 8.33(1), paragraph "a";

b. Provides a written protocol that is updated at least annually;

c. Is available through direct telecommunication for consultation, assistance, and direction, or provides physician backup to provide these services when the physician supervisor is not available;

d. Is an Iowa-licensed physician who has a working relationship with an authorized pharmacist within the physician's local provider service area.

8.33(3) *Administration of other adult immunizations by pharmacists.* A physician may prescribe, for an individual patient by prescription or medication order, other adult immunizations to be administered by an authorized pharmacist.

This rule is intended to implement Iowa Code sections 147.76, 155A.3, 155A.4, and 272C.3.

657—8.34(155A) Collaborative drug therapy management. An authorized pharmacist may only perform collaborative drug therapy management pursuant to protocol with a physician pursuant to the requirements of this rule. The physician retains the ultimate responsibility for the care of the patient. The pharmacist is responsible for all aspects of drug therapy management performed by the pharmacist.

8.34(1) Definitions.

“Authorized pharmacist” means an Iowa-licensed pharmacist whose license is in good standing and who meets the drug therapy management criteria defined in this rule.

“Board” means the board of pharmacy.

“Collaborative drug therapy management” means participation by an authorized pharmacist and a physician 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 community practice protocol. *“Collaborative practice”* also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and hospital clinic patients through a hospital practice protocol.

“Community practice protocol” means a written, executed agreement entered into voluntarily between an authorized pharmacist and a physician establishing drug therapy management for one or more of the pharmacist’s and physician’s patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 8.34(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.

“Drug therapy management criteria” means one or more of the following:

1. Graduation from a recognized school or college of pharmacy with a doctor of pharmacy (Pharm.D.) degree;
2. Certification by the Board of Pharmaceutical Specialties (BPS);
3. Certification by the Commission for Certification in Geriatric Pharmacy (CCGP);
4. Successful completion of a National Institute for Standards in Pharmacist Credentialing (NISPC) disease state management examination and credentialing by the NISPC;
5. Successful completion of a pharmacy residency program accredited by the American Society of Health-System Pharmacists (ASHP); or
6. Approval by the board of pharmacy.

“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 hospital pharmacists and physicians within a hospital and the hospital’s clinics as developed and determined by the hospital’s P&T committee. Such a protocol may apply to all pharmacists and physicians at a hospital or the hospital’s clinics or only to those pharmacists and physicians who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 8.34(3).

“IBM” means the Iowa board of medicine.

“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, osteopathic medicine and surgery, or osteopathy. 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.

8.34(2) Community practice protocol.

a. An authorized pharmacist shall engage in collaborative drug therapy management with a physician only under a written protocol that has been identified by topic and has been submitted to the board or a committee authorized by the board. A protocol executed after July 1, 2008, will no longer be required to be submitted to the board; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBM.

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 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 authorized 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 to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or to 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 securing the patient's written consent. If the patient's consent is not secured by the physician, the authorized pharmacist shall secure such and notify the patient's physician within 24 hours.

(6) Circumstances that shall cause the authorized 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 authorized pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy management 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 authorized pharmacist is to provide to the physician and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame within 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 authorized 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 an authorized pharmacist.
- (17) A description of the mechanism for the pharmacist and the 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 one authorized pharmacist and at least one physician.
 - d. The collaborative drug therapy protocol must be filed with the board, kept on file in the pharmacy, and be made available upon request of the board or the IBM. After July 1, 2008, protocols shall no longer be filed with the board but shall be maintained in the pharmacy and made available to the board and the IBM upon request.
 - 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 board. 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 board of changes in a protocol but the written notification shall be maintained in the pharmacy and made available upon request of the board or the IBM.
 - f. 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 shall 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.

8.34(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 the hospital's pharmacists.
- 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 pharmacists and physicians 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 to initiate a drug not included in the established protocol.
 - 2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or to 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 P&T committee 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.

657—8.35(155A) Pharmacy license. A pharmacy license issued by the board is required for all sites where prescription drugs are offered for sale or dispensed under the supervision of a pharmacist. A pharmacy license issued by the board is also required for all sites where drug information or other cognitive pharmacy services, including but not limited to drug use review and patient counseling, are provided by a pharmacist. The board may issue any of the following types of pharmacy licenses: a general pharmacy license, a hospital pharmacy license, a special or limited use pharmacy license, or a nonresident pharmacy license. Nonresident pharmacy license applicants shall comply with board rules regarding nonresident pharmacy practice except when specific exemptions have been granted. Applicants for general or hospital pharmacy practice shall comply with board rules regarding general or hospital pharmacy practice except when specific exemptions have been granted. Any pharmacy located within Iowa that dispenses controlled substances must also register pursuant to 657—Chapter 10.

8.35(1) Exemptions. Applicants who are granted exemptions shall be issued a “general pharmacy license with exemption,” a “hospital pharmacy license with exemption,” a “nonresident pharmacy license with exemption,” or a “limited use pharmacy license with exemption” and shall comply with the provisions set forth by that exemption. A written petition for exemption from certain licensure requirements shall be submitted pursuant to the procedures and requirements of 657—Chapter 34 and will be determined on a case-by-case basis.

8.35(2) Limited use pharmacy license. Limited use pharmacy license may be issued for nuclear pharmacy practice, correctional facility pharmacy practice, and veterinary pharmacy practice. Applications for limited use pharmacy license for these and other limited use practice settings shall be determined on a case-by-case basis.

8.35(3) Application form. Application for licensure and license renewal shall be on forms provided by the board. The application for a pharmacy license shall require an indication of the pharmacy ownership classification. If the owner is a sole proprietorship (100 percent ownership), the name and address of the owner shall be indicated. If the owner is a partnership or limited partnership, the names and addresses of all partners shall be listed or attached. If the owner is a corporation, the names and addresses of the officers and directors of the corporation shall be listed or attached. Any other pharmacy ownership classification shall be further identified and explained on the application. The application form shall require the name, signature, and license number of the pharmacist in charge. The names and license numbers of all pharmacists engaged in practice in the pharmacy, the names and registration numbers of all pharmacy technicians and pharmacy support persons working in the pharmacy, and the average number of hours worked by each pharmacist, pharmacy technician, and pharmacy support person shall be listed or attached. Additional information may be required of specific types of pharmacy license applicants. The application shall be signed by the pharmacy owner or the owner's, partnership's, or corporation's authorized representative.

8.35(4) License expiration and renewal. General pharmacy licenses, hospital pharmacy licenses, special or limited use pharmacy licenses, and nonresident pharmacy licenses shall be renewed before January 1 of each year. The fee for a new or renewal license shall be \$150.

a. Late payment penalty. Failure to renew the pharmacy license before January 1 following expiration shall require payment of the renewal fee and a penalty fee of \$150. Failure to renew the license before February 1 following expiration shall require payment of the renewal fee and a penalty fee of \$250. Failure to renew the license before March 1 following expiration shall require payment of the renewal fee and a penalty fee of \$350. Failure to renew the license before April 1 following expiration shall require payment of the renewal fee and a penalty fee of \$450 and may require an

appearance before the board. In no event shall the combined renewal fee and penalty fee for late renewal of a pharmacy license exceed \$600.

b. Delinquent license. If a license is not renewed before its expiration date, the license is delinquent and the licensee may not operate or provide pharmacy services to patients in the state of Iowa until the licensee renews the delinquent license. A pharmacy that continues to operate in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

8.35(5) Inspection of new pharmacy location. If the new pharmacy location within Iowa was not a licensed pharmacy immediately prior to the proposed opening of the new pharmacy, the pharmacy location shall require an on-site inspection by a pharmacy board inspector prior to the issuance of the pharmacy license. The purpose of the inspection is to determine compliance with requirements pertaining to space, library, equipment, security, temperature control, and drug storage safeguards. Inspection may be scheduled anytime following submission of necessary license and registration applications and prior to opening for business as a pharmacy. Prescription drugs, including controlled substances, may not be delivered to a new pharmacy location prior to satisfactory completion of the opening inspection.

8.35(6) Pharmacy license changes. When a pharmacy changes its name, location, ownership, or pharmacist in charge, a new pharmacy license application with a license fee as provided in subrule 8.35(4) shall be submitted to the board office. Upon receipt of the fee and properly completed application, the board will issue a new pharmacy license certificate. The old license certificate shall be returned to the board office within ten days of the change of name, location, ownership, or pharmacist in charge.

a. Location. A change of pharmacy location in Iowa shall require an on-site inspection of the new location as provided in subrule 8.35(5) if the new location was not a licensed pharmacy immediately prior to the relocation.

b. Ownership. A change of ownership of a currently licensed Iowa pharmacy, or a change of pharmacy location to another existing Iowa pharmacy location, shall not require on-site inspection pursuant to subrule 8.35(5). A new pharmacy license is required as provided in this subrule. A change of ownership effectively consists of a closing pharmacy, which is subject to the requirements for a closing pharmacy, and of a new pharmacy, which is subject to the requirements of a new pharmacy, with the possible exception of the on-site inspection as provided by this paragraph. In those cases in which the pharmacy is owned by a corporation, the sale or transfer of all stock of the corporation does not constitute a change of ownership provided the corporation that owns the pharmacy continues to exist and continues to own the pharmacy following the stock sale or transfer.

c. Pharmacist in charge. A change of pharmacist in charge shall require completion and submission of the application and fee for new pharmacy license.

(1) If a permanent pharmacist in charge has not been identified by the time of the vacancy, a temporary pharmacist in charge shall be identified. Written notification identifying the temporary pharmacist in charge, signed by the pharmacy owner or corporate officer and the temporary pharmacist in charge, shall be submitted to the board within 10 days following the vacancy.

(2) Within 90 days following the vacancy, a permanent pharmacist in charge shall be identified, and an application for pharmacy license, including the license fee as provided in subrule 8.35(4), shall be submitted to the board office.

8.35(7) Closing pharmacy. A closing pharmacy shall ensure that all patient and prescription records are transferred to another pharmacy that is held to the same standards of confidentiality as the closing pharmacy and that agrees to act as custodian of the records for the appropriate retention period for each record type as required by federal or state laws, rules, or regulations. A pharmacy shall not execute a sale or closing of a pharmacy unless there exists an adequate period of time prior to the pharmacy closing for delivery of the notifications to the pharmacist in charge, the board, the Drug Enforcement Administration (DEA), and pharmacy patients as required by this subrule. However, the provisions of this subrule regarding prior notifications to the board, the DEA, and patients shall not apply in the case of a board-approved emergency or unforeseeable closure, including but not limited to emergency board action, foreclosure, fire, or natural disaster.

a. Pharmacist in charge notification. At the first indication of a pending sale or at the commencement of negotiations regarding the sale or purchase of a pharmacy but not less than 21 days prior to the effective date of the sale of a pharmacy, the pharmacist in charge of the closing pharmacy, if that individual is not an owner of the closing pharmacy, shall be notified of the proposed sale. The owner of the closing pharmacy may direct the pharmacist in charge to maintain information regarding the pending closure of the pharmacy confidential until public notifications are required 14 days prior to the pharmacy closing. The pharmacist in charge of the closing pharmacy shall provide input and direction to the pharmacy owner regarding the responsibilities of the closing pharmacy, including the notifications, deadlines, and time lines established by this subrule. The pharmacist in charge of the closing pharmacy shall prepare patient notifications pursuant to paragraph 8.35(7) "d." At least 14 days prior to the effective date of the sale of a pharmacy, the pharmacist in charge of the purchasing or receiving pharmacy, if that individual is not an owner of the pharmacy, shall be notified of the pending transaction.

b. Board and DEA notifications. At least 14 days prior to the closing of a pharmacy, including a closing by sale of a pharmacy, a written notice shall be sent to the board and to the Drug Enforcement Administration (DEA) notifying those agencies of the intent to discontinue business or to sell the pharmacy and including the anticipated date of closing. These prior notifications shall include the name, address, DEA registration number, Iowa pharmacy license number, and Iowa controlled substances Act (CSA) registration number of the closing pharmacy and of the pharmacy to which prescription drugs will be transferred. Notifications shall also include the name, address, DEA registration number, Iowa pharmacy license number, and CSA registration number of the location at which prescription files, patient profiles, and controlled substance receipt and disbursement records will be maintained.

c. Terms of sale or purchase. If the closing is due to the sale of the pharmacy, a copy of the sale or purchase agreement, not including information regarding the monetary terms of the transaction, shall be submitted to the board upon the request of the board. The agreement shall include a written assurance from the closing pharmacy to the purchasing pharmacy that the closing pharmacy has given or will be giving notice to its patients as required by this subrule.

d. Patient notification. At least 14 days prior to closing, a closing pharmacy shall make a reasonable effort to notify all patients who had a prescription filled by the closing pharmacy within the last 18 months that the pharmacy intends to close, including the anticipated closing date.

(1) Written notification shall identify the pharmacy that will be receiving the patient's prescriptions and records, shall include information on the rights of the patient to transfer current prescriptions and patient records to a pharmacy of the patient's choosing including information on how such transfer may be accomplished, and shall include a form that may be completed by the patient and submitted to the closing pharmacy to authorize transfer of the patient's prescriptions and records to a pharmacy of the patient's choosing. Written notification shall also remind patients participating in a program or agreement that restricts the patient's pharmacy services to the closing pharmacy that the patient must contact the program or the party to the agreement to arrange for a change of pharmacy to the purchasing pharmacy or another pharmacy of the patient's choosing.

(2) Written notification shall be delivered to each patient at the patient's last address on file with the closing pharmacy by direct mail or personal delivery and also by public notice. Public notice refers to the display, in a location and manner clearly visible to patients, of signs in pharmacy pickup locations including drive-through prescription pickup lanes, on pharmacy or retail store entry and exit doors, or at pharmacy prescription counters. In addition, notice may be posted on the pharmacy's Web site, displayed on a marquee or electronic sign, communicated via automated message on the pharmacy's telephone system, or published in one or more local newspapers or area shopper publications.

e. Patient communication by receiving pharmacy. A pharmacy receiving the patient records of another pharmacy shall not contact the patients of the closing pharmacy until after the transfer of those patient records from the closing pharmacy to the receiving pharmacy and after the closure of the closing pharmacy. The receiving pharmacy shall post or publish notice to patients of their right to transfer current prescriptions and patient records to a pharmacy of the patient's choosing, including information on how

such transfer can be accomplished. A notice posted at the receiving or purchasing pharmacy shall be maintained for a minimum 90 days following the transfer of patient records from the closing pharmacy.

f. Prescription drug inventory. A complete inventory of all prescription drugs being transferred shall be taken as of the close of business. The inventory shall serve as the ending inventory for the closing pharmacy as well as a record of additional or starting inventory for the pharmacy to which the drugs are transferred. A copy of the inventory shall be included in the records of each licensee.

(1) DEA Form 222 is required for transfer of Schedule II controlled substances.

(2) The inventory of controlled substances shall be completed pursuant to the requirements in 657—10.35(124,155A).

(3) The inventory of all noncontrolled prescription drugs may be estimated.

(4) The inventory shall include the name, strength, dosage form, and quantity of all prescription drugs transferred.

(5) Controlled substances requiring destruction or other disposal shall be transferred in the same manner as all other drugs. The new owner is responsible for the disposal of these substances as provided in rule 657—10.18(124).

g. Surrender of certificates and forms. The pharmacy license certificate and CSA registration certificate of the closing pharmacy shall be returned to the board office within ten days of closing. The DEA registration certificate and all unused DEA Forms 222 shall be returned to the DEA within ten days of closing. All authorizations to utilize the DEA's online controlled substances ordering system (CSOS) and all digital certificates issued for the purpose of ordering controlled substances for the closing pharmacy shall be canceled or revoked within ten days of closing.

h. Signs at closed pharmacy location. A location that no longer houses a licensed pharmacy shall not display any sign, placard, or other notification, visible to the public, which identifies the location as a pharmacy. A sign or other public notification that cannot feasibly be removed shall be covered so as to conceal the identification as a pharmacy. Nothing in this paragraph shall prohibit the display of a public notice to patients, as required in paragraph 8.35(7) "d," for a reasonable period not to exceed six months following the pharmacy closing.

8.35(8) Failure to complete licensure. An application for a pharmacy license, including an application for registration pursuant to 657—Chapter 10, if applicable, will become null and void if the applicant fails to complete the licensure process within six months of receipt by the board of the required applications. The licensure process shall be complete upon the pharmacy's opening for business at the licensed location following an inspection rated as satisfactory by an agent of the board if such an inspection is required pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9526B, IAB 6/1/11, effective 7/6/11]

These rules are intended to implement Iowa Code sections 124.101, 124.301, 124.306, 124.308, 126.10, 126.11, 126.16, 135C.33, 147.7, 147.55, 147.72, 147.74, 147.76, 155A.2 through 155A.4, 155A.6, 155A.10, 155A.12 through 155A.15, 155A.19, 155A.20, 155A.27 through 155A.29, 155A.32, and 155A.33.

[Filed 4/11/68; amended 11/14/73]

[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]

[Filed 11/9/77, Notice 10/5/77—published 11/30/77, effective 1/4/78]

[Filed emergency 12/9/77—published 12/28/77, effective 12/9/77]

[Filed 10/20/78, Notice 8/9/78—published 11/15/78, effective 1/9/79]

[Filed 12/2/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]

[Filed 12/21/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]

[Filed 1/8/79, Notice 11/29/78—published 1/24/79, effective 2/28/79]

[Filed 8/28/79, Notice 5/30/79—published 9/19/79, effective 10/24/79]

[Filed 12/7/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]

[Filed 2/22/80, Notice 10/3/79—published 3/19/80, effective 4/23/80]

[Filed emergency 4/22/80—published 5/14/80, effective 4/22/80]

[Filed 12/1/80, Notice 10/15/80—published 12/24/80, effective 1/28/81]

- [Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 4/8/81]
[Filed 5/27/81, Notice 4/1/81—published 6/24/81, effective 7/29/81]
 [Filed emergency 7/28/81—published 8/19/81, effective 8/1/81]
 [Filed emergency 9/14/81—published 9/30/81, effective 9/30/81]
[Filed 7/28/82, Notice 3/17/82—published 8/18/82, effective 9/22/82]
 [Filed emergency 8/26/82—published 9/15/82, effective 9/22/82]
[Filed 9/10/82, Notice 6/9/82—published 9/29/82, effective 11/8/82]
[Filed emergency 10/6/82—published 10/27/82, effective 10/27/82]◊
[Filed emergency 12/2/82—published 12/22/82, effective 12/22/82]
[Filed 11/18/83, Notice 8/3/83—published 12/7/83, effective 1/11/84]
 [Filed 1/13/84, Notice 11/9/83—published 2/1/84, effective 3/7/84]
[Filed 6/22/84, Notice 4/11/84—published 7/18/84, effective 8/22/84]
 [Filed emergency 7/13/84—published 8/1/84, effective 7/13/84]
[Filed 9/21/84, Notice 7/18/84—published 10/10/84, effective 11/14/84]
[Filed 2/22/85, Notice 11/21/84—published 3/13/85, effective 4/18/85]
 [Filed emergency 6/18/85—published 7/3/85, effective 7/1/85]
[Filed 8/30/85, Notice 7/3/85—published 9/25/85, effective 10/30/85]◊
[Filed 11/27/85, Notice 8/28/85—published 12/18/85, effective 1/22/86]
[Filed 9/19/86, Notice 6/4/86—published 10/8/86, effective 11/12/86]
[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]
 [Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed 1/21/88, Notice 11/4/87—published 2/10/88, effective 3/16/88]
[Filed 3/29/88, Notice 1/27/88—published 4/20/88, effective 5/25/88]
[Filed 3/29/88, Notice 2/10/88—published 4/20/88, effective 5/25/88]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]◊
 [Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed 12/26/89, Notice 10/4/89—published 1/24/90, effective 2/28/90]
[Filed 3/19/90, Notice 1/10/90—published 4/18/90, effective 5/23/90]
[Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
[Filed 1/29/91, Notice 6/13/90—published 2/20/91, effective 3/27/91]
[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
[Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
 [Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
[Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 1/21/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
 [Filed 3/12/92, Notice 1/8/92—published 4/1/92, effective 5/6/92]
 [Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92]
 [Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]
 [Filed 2/5/93, Notice 11/11/92—published 3/3/93, effective 4/8/93]
[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]
[Filed 3/21/94, Notices 10/13/93, 12/8/93—published 4/13/94, effective 5/18/94]
 [Filed 6/24/94, Notice 4/13/94—published 7/20/94, effective 8/24/94]
[Filed 11/30/94, Notices 5/11/94, 7/20/94—published 12/21/94, effective 1/25/95]
 [Filed 3/22/95, Notice 11/9/94—published 4/12/95, effective 5/31/95]
[Filed 10/6/95, Notices 6/7/95, 8/16/95—published 10/25/95, effective 1/1/96]
 [Filed emergency 12/14/95—published 1/3/96, effective 1/1/96]
 [Filed 12/10/96, Notice 8/28/96—published 1/1/97, effective 2/5/97]
 [Filed 2/27/97, Notice 8/28/96—published 3/26/97, effective 4/30/97]
 [Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
 [Filed 6/23/97, Notice 3/26/97—published 7/16/97, effective 8/20/97]
[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
 [Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]

[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]
[Filed 4/22/99, Notice 3/10/99—published 5/19/99, effective 6/23/99]
[Filed 11/23/99, Notice 6/2/99—published 12/15/99, effective 1/19/00]
[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
[Filed 11/9/00, Notice 4/19/00—published 11/29/00, effective 1/3/01]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed 10/22/04, Notice 5/12/04—published 11/10/04, effective 12/15/04]
[Filed 6/2/05, Notice 3/16/05—published 6/22/05, effective 7/27/05]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 5/17/06, Notice 2/15/06—published 6/7/06, effective 10/1/06]
[Filed 11/30/06, Notice 9/27/06—published 12/20/06, effective 1/24/07]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07][◊]
[Filed 8/3/07, Notice 5/9/07—published 8/29/07, effective 10/3/07]
[Filed 8/3/07, Notice 6/20/07—published 8/29/07, effective 10/3/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 11/13/07, Notice 8/29/07—published 12/5/07, effective 1/9/08]
[Filed 5/19/08, Notice 3/26/08—published 6/18/08, effective 7/23/08]
[Filed 9/5/08, Notice 7/2/08—published 9/24/08, effective 10/29/08]
[Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
[Filed ARC 8171B (Notice ARC 7910B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
[Filed ARC 8539B (Notice ARC 8269B, IAB 11/4/09), IAB 2/24/10, effective 4/1/10]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 8671B (Notice ARC 8414B, IAB 12/30/09), IAB 4/7/10, effective 5/12/10]
[Filed ARC 9409B (Notice ARC 9194B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]
[Filed ARC 9526B (Notice ARC 9295B, IAB 12/29/10), IAB 6/1/11, effective 7/6/11]

[◊] Two or more ARCs