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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Corrections Department[201]

Replace Chapter 37

Human Services Department[441]

Replace Chapter 78

Replace Chapter 83

Environmental Protection Commission[567]

Replace Chapter 50

Replace Chapters 52 and 53

Replace Chapter 64

Natural Resource Commission[571]

Replace Chapter 61

Regents Board[681]

Replace Chapter 1

Transportation Department[761]

Replace Analysis

Replace Chapter 4

CHAPTER 37
IOWA STATE INDUSTRIES
[Prior to 10/1/83, Social Services[770] Ch 23]
[Prior to 3/20/91, Corrections Department[291]]

201—37.1(904) Mission and function. Iowa state industries, which is established by Iowa Code chapter 904, consists of a policy board, a director, and manufacturing, farming, surplus and private sector work programs. Each business is entirely self-funded and receives no state appropriation.

37.1(1) The mission of Iowa state industries is to employ staff and offenders who are dedicated to providing exceptional service, reasonable prices and quality products.

37.1(2) Iowa state industries is charged with making available to offenders of the state correctional institutions opportunities for work in meaningful jobs that will ensure the offenders' chances of a successful return to society as law-abiding and self-supporting members of the community upon the offenders' release. Iowa state industries is further charged with enabling offenders to work in order to provide financial assistance to their dependents, make restitution, pay the cost of board and maintenance in a correctional institution, and accumulate savings upon their eventual return to the community.

201—37.2(904) Sale of products.

37.2(1) Iowa state industries shall sell products to any tax-supported institution or governmental subdivision in any level of government, including state, county, city or school. Iowa state industries may sell products to employees of such entities.

37.2(2) Iowa state industries may sell products to nonprofit organizations such as parochial schools, churches, or fraternal organizations and employees of such nonprofit organizations.

37.2(3) Iowa state industries may sell products to nonprofit health care facilities serving Medicaid or social security patients.

37.2(4) Sales will not generally be solicited from the general public. However, the state director of Iowa state industries may determine with the advice of the prison industries advisory board that limited public sales will be made when the sales to political subdivisions are insufficient to justify continued operation of a shop.

37.2(5) Iowa state industries may sell products to a general contractor when the products purchased will be sold to a public entity as provided in subrules 37.2(1) to 37.2(3). The public entity shall submit a written request to Iowa state industries specifying the products and quantities to be purchased. Such sales shall be limited to contractors involved in construction, renovation, and remodeling projects. Sales to a general contractor shall be approved by the Iowa prison industries advisory board.

This rule is intended to implement Iowa Code section 904.815.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.3(904) Catalogs. Catalogs are available online at the Iowa state industries Internet home page <http://www.iaprisoinind.com>, or at the Iowa state industries showroom located at 1445 East Grand Avenue, Des Moines, Iowa 50316. Requests for mailed copies may be sent to the Iowa state industries showroom address.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.4(904) Offices. The showroom and main office for Iowa state industries are located at 1445 East Grand Avenue, Des Moines, Iowa 50316; telephone (515)242-5778. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.5(904) Obtaining information from or reporting information to Iowa state industries. Persons wishing to obtain information from or report information to Iowa state industries may contact the Iowa State Industries Business Office, P.O. Box 430, 406 North High Street, Anamosa, Iowa 52205; telephone (319)462-3504. Office hours are 7:30 a.m. to 4 p.m., Monday through Friday, excluding holidays. Information may also be found on the Iowa state industries Web site: <http://www.iaprisoinind.com>.

201—37.6(904) Internet Web site. Iowa State Industries Internet home page is located at <http://www.iaprisonind.com>.

201—37.7(904) Procurement of goods and services. The provisions of 11—Chapter 117 are hereby adopted by reference with the following amendments.

1. Strike “Department of Administrative Services” and insert in lieu thereof “Iowa State Industries” in all rules except rule 11—117.11(8A), which pertains to procurement of information technology devices and services.

2. In lieu of the definitions of “Department” and “Director,” insert the following:

“Department” means the division of Iowa state industries.

“Director” means the director of the division of Iowa state industries or the director’s designee.

3. Rules 11—117.7(8A) and 11—117.15(8A) and subrule 117.4(3) are not adopted.

4. In lieu of the text of 11—subrule 117.14(1), insert the following: “Purchase of goods. An agency may acquire goods not otherwise available through a master agreement in accordance with the procurement threshold guidelines in 11—subrule 117.5(3).”

5. In lieu of the text of rule 11—117.20(8A), insert the following: “Appeal process. Vendors may appeal actions by Iowa state industries under these rules as follows:

“Step 1. Appeals shall be filed in writing to the Business Manager, Iowa State Industries, 406 North High Street, Anamosa, Iowa 52205, within 5 working days of notification of the action being appealed. The appeal shall state the specific grounds upon which the vendor is challenging the action. The business manager, Iowa state industries, shall notify the vendor in writing of the decision within 10 working days.

“Step 2. If the appeal is not resolved, it may be further appealed by the vendor to the Director of Iowa State Industries, Jessie Parker State Office Bldg., 510 East 12th Street, Des Moines, Iowa 50319, within 10 working days of the notification of the Step 1 appeal response. The director of Iowa state industries shall notify the vendor in writing of the decision within 15 working days.

“Step 3. An unresolved appeal to the Director of Iowa State Industries shall be referred to the Director of the Department of Corrections, Jessie Parker State Office Bldg., 510 East 12th Street, Des Moines, Iowa 50319, within 10 working days of the notification of the Step 2 appeal response. The director of the department of corrections shall notify the vendor in writing of the decision within 15 working days.”

This rule is intended to implement Iowa Code section 904.813.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.8(904) Prison industries advisory board. The state director of Iowa state industries has, by statute, the advice and counsel of the prison industries advisory board.

37.8(1) Rules of procedure. The seven-member prison industries advisory board is represented by five appointees of the governor, one appointee of the parole board, and one appointee of the director, department of corrections. The principal duties of the advisory board are to promulgate and adopt rules and to advise the director, Iowa state industries, regarding the management of Iowa state industries.

a. A quorum shall consist of five members.

b. When a quorum is present, a position is carried by a majority of the members of the board.

c. The board shall meet at least once per calendar quarter. The meetings will be held at the seat of government unless notification is given otherwise. Other meetings shall be held at the call of the chairperson or of any three members when necessary for the board to discharge its duties.

(1) Notice of the meetings shall be given pursuant to Iowa Code chapter 21.

(2) When it is necessary to hold an emergency meeting, the communications media shall be notified as far in advance of the meeting as time allows. The nature of the emergency shall be stated in the minutes.

d. Copies of the minutes are kept on file in the office of the director, Iowa state industries. Minutes are available from the director’s office to interested persons upon request. Organizations may request to be placed on a mailing list. Copies of administrative rules and other materials considered are made a part of the minutes by reference.

e. In cases not covered by these rules, Robert’s Rules of Order shall govern.

37.8(2) Meetings. All meetings will be open to the public unless specifically allowed to be closed under Iowa Code chapter 21.

a. Persons wishing to make a presentation shall make such request to the director, Iowa state industries, or to any member of the board at least one week in advance of the scheduled meeting.

b. Persons requesting to make a presentation are requested to submit one written copy of their remarks for the record. Presentations may be made at the discretion of the chairperson and only upon matters appearing on the agenda.

c. Persons who have not made previous arrangements to speak at a meeting may be given the floor at the discretion of the chairperson.

37.8(3) The chairperson may appoint committees of the board as necessary to conduct the business of the board. Committee meetings shall comply with Iowa Code chapter 21.

37.8(4) The board shall:

a. Promulgate and adopt rules.

b. Advise the state director of Iowa state industries regarding the management of Iowa state industries.

This rule is intended to implement Iowa Code section 904.803.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.9(904) Private sector employment projects.

37.9(1) Definitions.

“*Advisory board*” means the prison industries advisory board.

“*Deputy director of prison industries*” means the department of corrections deputy director responsible for the day-to-day operations of prison industries including private sector individuals.

“*Director*” means the chief executive officer of the department of corrections.

“*Wage range*” means the wage paid that is commensurate to wages paid to persons in similar jobs outside the correctional institution.

“*Workforce development board*” means the state workforce development board.

“*Workforce development director*” means the chief executive officer of the department of workforce development.

37.9(2) Preapplication requirement. Prior to submitting an application to the deputy director of prison industries for a private sector employment project, the employer shall place with the nearest workforce development center a job order with a duration of at least 30 days. The job order shall be listed statewide in all centers and on the department of workforce development’s jobs Internet site.

37.9(3) Employer application.

a. Private sector employers requesting offender labor must submit the following to the deputy director of prison industries:

- (1) Work program, including job description;
- (2) Proposed wage rate;
- (3) Description of job site;
- (4) Duration of the work; and
- (5) A copy of the job order listing with workforce development.

b. Upon receiving a written proposal to use offenders in a private sector work program, the deputy director of prison industries shall provide a copy of the private sector work proposal including job descriptions and proposed wages to the workforce development director.

c. The deputy director of prison industries shall send a letter to the department of workforce development requesting verification of the employer’s 30-day job listing, the wage range for the job(s) the offenders will perform, the current unemployment rate in the county where the employer is located, and the current employment level of the company that will employ the offenders.

d. The deputy director of prison industries and the warden/superintendent at the proposed institution shall review the proposed projects with the board of supervisors and the sheriff in the county where the project will be located.

37.9(4) Verification. The workforce development director shall verify the employment levels and wage range for similar jobs in the area and provide to the deputy director of prison industries, in writing:

- a. Verification of the employer's 30-day job listing;
- b. The number of qualified applicant referrals and hires made as a result of the job order;
- c. The wage range for the proposed job(s);
- d. The current unemployment rate for the county where the employer is located; and
- e. The current employment levels of the company that will employ the offenders based upon the most recent quarter for which data is available.

37.9(5) Wage range. The deputy director of prison industries shall obtain employment levels in the locale of the proposed job(s) and the wage range for the job(s) in question from the department of workforce development prior to authorizing any private sector work program. The deputy director of prison industries will consider the wage range from the department of workforce development for the appropriate geographic area for which occupational wage information is available. The appropriate geographic area may be statewide. To reduce possible displacement of civilian workers, the deputy director of prison industries shall advise prospective employers and eligible offenders of the following requirements:

- a. Offenders shall not be eligible for unemployment compensation while incarcerated.
- b. Before the employer initiates work utilizing offender labor, the deputy director of prison industries shall provide the baseline number of jobs as established by the department of workforce development.

c. In January and July of each year, the deputy director of prison industries shall receive from the department of workforce development the actual number of civilian workers by employer and shall compile a side-by-side comparison for each employer. A copy of the side-by-side comparison will be provided to the advisory board and workforce development director semiannually.

37.9(6) Ineligible projects. The deputy director of prison industries shall evaluate the information from the department of workforce development to verify nondisplacement of civilian workers. Employment of offenders in private industry shall not displace employed workers, apply to skills, crafts, or trades in which there is a local surplus of labor, or impair existing contracts for employment or services.

37.9(7) Notification and review.

a. The deputy director of prison industries shall provide a copy of the private sector work proposal and the department of workforce development review of the private sector work proposal to the following:

- (1) Governor's office;
- (2) Speaker of the house;
- (3) President of the senate;
- (4) Warden/superintendent at the proposed work site;
- (5) Local labor organization(s);
- (6) Director of workforce development; and
- (7) Department of Justice, Washington, DC.

b. Within 14 calendar days of receiving the department of workforce development review, the deputy director of prison industries will consolidate the recommendations for review and approval by the director of corrections.

37.9(8) Prison industries advisory board review.

a. Following approval by the director of corrections, the deputy director of prison industries shall forward the final proposal to the prison industries advisory board with the recommendation to approve or disapprove the work program, including all correspondence from the department of workforce development, the Department of Justice, and any local official who has offered comments.

b. The deputy director of prison industries shall provide written documentation to the prison industries advisory board confirming that the proposed work project will not displace civilian workers. If displacement occurs, the deputy director of prison industries shall advise the private employer that

the employer will be given 30 days to become compliant or the department of corrections will terminate the use of offender labor.

37.9(9) Disputes.

a. Anyone who believes that the private sector work program violates this rule shall advise the department of workforce development. A written complaint may be filed in accordance with workforce development board rule 877—1.5(84A). The workforce development director shall consult with the deputy director of prison industries before the workforce development board makes a final recommendation(s) to resolve any complaint.

b. The deputy director of prison industries will assist the department of workforce development in compiling all information necessary to resolve the dispute. The workforce development board shall notify the deputy director of prison industries and interested parties in writing of the recommended action to resolve a complaint, which will be binding on all parties.

This rule is intended to implement Iowa Code section 904.809.

[ARC 2056C, IAB 7/8/15, effective 8/12/15]

201—37.10(904) Utilization of offender labor in construction and maintenance projects.

37.10(1) Definitions.

“*Director*” means the chief executive officer of the department of corrections.

“*Employer*” means a contractor or subcontractor providing maintenance or construction services under contract to the department of corrections or under the department of administrative services.

“*Workforce development director*” means the chief executive officer of the department of workforce development.

37.10(2) Scope. Utilization of offender labor applies only to contractors or subcontractors providing construction or maintenance services to the department of corrections. The contract authority for providing construction or maintenance services may be the department of administrative services.

37.10(3) Employer application. Employers working under contract with the state of Iowa may submit an application to the department of corrections to employ offenders. Requests for such labor shall not include work release offenders assigned to community-based corrections under Iowa Code chapter 905.

a. Prior to submitting an application, the employer shall place with the nearest workforce development center a job order with a duration of at least 30 days. The job order shall contain the prevailing wage determined by the department of workforce development. The job order shall be listed statewide in all centers and on the department of workforce development’s jobs Internet Web site.

b. The employer’s application shall include:

- (1) Scope of work, including type of work and required number of workers;
- (2) Proposed wage rate;
- (3) Location;
- (4) Duration; and
- (5) Reason for utilizing offender labor.

c. The department of corrections shall verify through the department of workforce development the employer’s 30-day job listing, the average wage rate for the job(s) the offenders will perform, the current unemployment rate in the county where the employer is located, and the current employment level of the employer that will employ the offenders.

37.10(4) Verification. The director of workforce development shall verify the employment levels and prevailing wages paid for similar jobs in the area and provide to the director, in writing:

- a.* Verification of the employer’s 30-day job listing;
- b.* The number of qualified applicant referrals and hires made as a result of the job order;
- c.* The average wage rate for the proposed job(s);
- d.* The wage range;
- e.* The prevailing wage as determined by the U.S. Department of Labor;
- f.* The current unemployment rate for the county where the employer is located;

g. The current employment levels of the employer that will employ the offenders based upon the most recent quarter for which data is available.

37.10(5) Safety training. The employer shall document that all offenders employed in construction and maintenance projects receive a ten-hour safety course provided free of charge by the department of workforce development or by a trainer with the appropriate authorization from the Occupational Safety and Health Administration Training Institute.

37.10(6) Prevailing wages.

a. The director will not authorize an employer to employ offenders in hard labor programs without obtaining from the department of workforce development employment levels in the locale of the proposed jobs and the prevailing wages for the jobs in question. The average wage rate and wage range from the department of workforce development will be based on the appropriate geographic area for which occupational wage information is available. The appropriate geographic area may be statewide.

b. To reduce any potential displacement of civilian workers, the director shall advise prospective employers and eligible offenders of the following requirements:

(1) Offenders will not be eligible for unemployment compensation while incarcerated.

(2) Before the employer initiates work utilizing offender labor, the director shall provide the baseline number of jobs as established by the department of workforce development.

(3) If the contract to employ offender labor exceeds six months, the director shall:

1. Request and receive from the workforce development director the average wage rates and wage ranges for jobs currently held by offenders and current employment levels of employers employing offenders; and

2. Compile a side-by-side comparison of each employer.

37.10(7) Disputes. Anyone who believes that the employer's application violates this rule shall present concerns in writing to the workforce development board. A written complaint may be filed with the workforce development board for any dispute arising from the implementation of the employer's application in accordance with workforce development board rule 877—1.6(84A). The workforce development board shall consult with the director prior to making recommendations. The director will assist the workforce development board in compiling all information necessary to resolve the dispute. The workforce development board shall notify the director and interested parties in writing of the corrective action plan to resolve the dispute, which will be binding on all parties.

This rule is intended to implement Iowa Code section 904.701.

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 7/31/78, Notice 5/31/78—published 8/23/78, effective 9/27/78]

[Filed 10/23/81, Notice 8/19/81—published 11/11/81, effective 12/16/81]

[Filed 1/29/82, Notice 11/11/81—published 2/17/82, effective 3/24/82]¹

[Filed emergency 8/29/83—published 9/14/83, effective 10/1/83]

[Filed emergency 7/22/88 after Notice 6/15/88—published 8/10/88, effective 7/22/88]

[Filed emergency 2/20/91—published 3/20/91, effective 2/20/91]

[Filed 6/9/00, Notice 4/5/00—published 6/28/00, effective 8/2/00][◇]

[Filed emergency 8/18/00—published 9/6/00, effective 8/18/00]

[Filed emergency 10/13/00—published 11/1/00, effective 10/13/00]

[Filed 4/9/08, Notice 1/16/08—published 5/7/08, effective 6/11/08]

[Filed ARC 2056C (Notice ARC 1990C, IAB 5/13/15), IAB 7/8/15, effective 8/12/15]

[◇] Two or more ARCs

¹ Prior to 3/20/91, see Prison Industries Advisory Board 635—Chapter 1

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

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

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

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

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

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

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

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

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

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

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

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

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

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

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

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

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

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

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

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

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

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

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

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

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

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

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(20) Transplants.

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

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

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler’s syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin’s lymphomas; Hodgkin’s lymphoma; relapsed Hodgkin’s lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin’s disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms’ tumor; Ewing’s sarcoma; metastatic germ cell tumor; or multiple myeloma.

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

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

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

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

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the Iowa Medicaid enterprise medical services prior authorization unit. (Cross-reference 78.1(19) and 78.28(1)“f.”) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

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

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

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

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

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

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

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

d. Payment will not be made for any transplant not specifically listed in paragraph “a.”

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

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

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

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

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

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

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

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

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

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

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

[ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0846C, IAB 7/24/13, effective 7/1/13; ARC 1052C, IAB 10/2/13, effective 11/6/13; ARC 1297C, IAB 2/5/14, effective 4/1/14]

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

78.2(1) Qualified prescriber. All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

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

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

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

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

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

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

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

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

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

b. Payment is not made for:

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

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

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

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

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

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

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

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

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

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

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

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

- Acetaminophen tablets 325 mg, 500 mg
- Acetaminophen elixir 160 mg/5 ml
- Acetaminophen solution 100 mg/ml
- Acetaminophen suppositories 120 mg
- Artificial tears ophthalmic solution
- Artificial tears ophthalmic ointment
- Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
- Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
- Aspirin tablets, buffered 325 mg
- Bacitracin ointment 500 units/gm
- Benzoyl peroxide 5%, gel, lotion
- Benzoyl peroxide 10%, gel, lotion
- Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
- Calcium carbonate suspension 1250 mg/5 ml
- Calcium carbonate tablets 600 mg
- Calcium carbonate-vitamin D tablets 500 mg-200 units
- Calcium carbonate-vitamin D tablets 600 mg-200 units
- Calcium citrate tablets 950 mg (200 mg elemental calcium)
- Calcium gluconate tablets 650 mg
- Calcium lactate tablets 650 mg
- Cetirizine hydrochloride liquid 1 mg/ml
- Cetirizine hydrochloride tablets 5 mg
- Cetirizine hydrochloride tablets 10 mg
- Chlorpheniramine maleate tablets 4 mg
- Clotrimazole vaginal cream 1%
- Diphenhydramine hydrochloride capsules 25 mg
- Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
- Epinephrine racemic solution 2.25%
- Ferrous sulfate tablets 325 mg
- Ferrous sulfate elixir 220 mg/5 ml
- Ferrous sulfate drops 75 mg/0.6 ml
- Ferrous gluconate tablets 325 mg
- Ferrous fumarate tablets 325 mg
- Guafenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
- Ibuprofen suspension 100 mg/5 ml
- Ibuprofen tablets 200 mg
- Insulin
- Lactic acid (ammonium lactate) lotion 12%
- Loperamide hydrochloride liquid 1 mg/5 ml
- Loperamide hydrochloride tablets 2 mg
- Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
 Magnesium oxide tablets 400 mg
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Multiple vitamin and mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder

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

78.2(6) *Quantity prescribed and dispensed.*

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

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

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

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

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Recipient selection and education.

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

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

- Intake.
- Preparation and waiting period.
- Preadmission.
- Hospitalization.
- Discharge planning.
- Follow-up.

b. Staffing and resource commitment.

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

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

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

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

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

The team should consist of:

A surgeon director.

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

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

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

- Anesthesiology.
- Cardiology.
- Dialysis.
- Gastroenterology.
- Hepatology.
- Immunology.
- Infectious diseases.
- Nephrology.
- Neurology.
- Pathology.
- Pediatrics.
- Psychiatry.
- Pulmonary medicine.
- Radiology.
- Rehabilitation medicine.

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

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

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

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

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

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

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

c. Experience and survival rates.

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
 (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

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

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

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

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

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

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

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

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) “a”(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross-reference 78.28(2) “a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) “a”(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed,

the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

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

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

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

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

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross-reference 78.28(2) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross-reference 78.28(2) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

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

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

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

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

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

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

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross-reference 78.28(2) "c")

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe

handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated

foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“*c.*” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

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

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
 2. Verification of lenses after fabrication.
 3. Adjustment and alignment of completed lens order.
- (2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a. Corrected curve lenses, unless clinically contraindicated.
- b. Standard plastic, plastic and metal combination, or metal frames.
- c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross-reference 78.28(3))

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

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b. Glasses for occupational eye safety.
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

78.6(6) Therapeutically certified optometrists. Rescinded IAB 9/5/12, effective 11/1/12.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12]

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

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

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

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

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

78.8(2) Indications and limitations of coverage.

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

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

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

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

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

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

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

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph "c" of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

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

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

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

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

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

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

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

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

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

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and

other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

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

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

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

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

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

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

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

before the claim for service is submitted for reimbursement.

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

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week

(except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

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

78.9(8) Medical social services.

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

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

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

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

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

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

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

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.

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

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

(1) Aged 16 or under.

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

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

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

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

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

(8) Demonstrated disturbance in maternal and infant bonding.

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

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

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

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

(2) History of severe respiratory distress.

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

(4) Disabling birth injuries.

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

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

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

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

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

(10) Nutrition or feeding problems.

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

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

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

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

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

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

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

a. Definitions.

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

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

Private duty nursing or personal care services do not include:

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

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

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

b. Requirements.

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

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

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

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services

to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

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

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

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

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

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

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

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

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

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

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

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

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

5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5) "f" for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) "d" for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) "g" and "j" for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) "j" for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) "a" for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) "c" for prior authorization requirements.

Insulin infusion pump. See 78.10(5) "b" and 78.10(5) "e" for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) "i" for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) "a" and 78.10(2) "c."

Patient lift. See 78.10(5) "h" for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5) "f" for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from

the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

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

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member’s condition may improve sometime in the future.

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

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5) “l” for prior authorization requirements.

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

(5) Orthotic devices. See 78.10(3) “c” for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

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

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) "e" for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) "m" for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

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

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

(1) Has a sip 'n puff attachment, or

(2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or

(3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

(1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and

(2) Needs upper body support while sitting, and

(3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary

in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14]

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

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

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

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

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

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

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

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

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one

ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

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

78.12(1) Definitions.

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

1. Addressing the mental and functional disabilities that negatively affect a member’s integration and stability in the community and quality of life;
2. Improving a member’s health and well-being related to the member’s mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member’s best possible functional level; and
3. Promoting a member’s mental health recovery and resilience through increasing the member’s ability to manage symptoms.

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

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

“Mental disorder” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

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

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

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

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

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in

acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

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

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

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

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

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

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

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

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

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

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

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

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

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

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5) "a" if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4) "c"(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.
- (6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a.* Transportation to obtain services not covered by Iowa Medicaid;
- b.* Transportation to providers that are not enrolled in Iowa Medicaid;
- c.* Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d.* Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e.* Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f.* Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. *No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. *No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. *Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4) “b”):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

“*Custom-molded shoe*” means a shoe that:

1. Has been constructed over a cast or model of the recipient’s foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient’s conditions and needs; and
4. Has some form of closure.

“*Depth shoe*” means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“*Insert*” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.

- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)“*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients’ treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“*b*”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“*b*”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)“*b.*”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor’s degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program’s description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “*c*” to “*h*” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system,

community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from

another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.
4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.
5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.
6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.
7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.
8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)“b”(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)“b”(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient’s condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient’s practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient’s illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)“b”(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number “5” under 78.19(1)“b”(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

- (1) The patient's current medical condition and functional abilities, including any disabling condition.
 - (2) The physician's signature and date (within the certification period).
 - (3) Certification period.
 - (4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)
 - (5) The place services are rendered.
 - (6) Dates of prior hospitalization (if applicable or known).
 - (7) Dates of prior surgery (if applicable or known).
 - (8) The date the patient was last seen by the physician (if available).
 - (9) A diagnosis relevant to the medical necessity for treatment.
 - (10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
 - (11) A brief summary of the initial evaluation or baseline.
 - (12) The patient's prognosis.
 - (13) The services to be rendered.
 - (14) The frequency of the services and discipline of the person providing the service.
 - (15) The anticipated duration of the services and the estimated date of discharge (if applicable).
 - (16) Assistive devices to be used.
 - (17) Functional limitations.
 - (18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
 - (19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
 - (20) Quantitative, measurable, short-term and long-term functional goals.
 - (21) The period of time of a session.
 - (22) Prior treatment (history related to current diagnosis) if available or known.
- b.* The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

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

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

- a. Prenatal and postpartum medical care.
- b. Health education, which shall include:
 - (1) Importance of continued prenatal care.
 - (2) Normal changes of pregnancy including both maternal changes and fetal changes.
 - (3) Self-care during pregnancy.
 - (4) Comfort measures during pregnancy.
 - (5) Danger signs during pregnancy.
 - (6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.
 - (7) Preparation for baby including feeding, equipment, and clothing.
 - (8) Education on the use of over-the-counter drugs.
 - (9) Education about HIV protection.
- c. Home visit.
- d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).
- e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

- a. Rescinded IAB 12/3/08, effective 2/1/09.
- b. Education, which shall include as appropriate education about the following:
 - (1) High-risk medical conditions.
 - (2) High-risk sexual behavior.
 - (3) Smoking cessation.
 - (4) Alcohol usage education.
 - (5) Drug usage education.
 - (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client’s family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child’s discharge from the hospital, which shall include:
 - (1) Assessment of mother’s health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.

- (5) Assessment of infant health.
- (6) Infant care.
- (7) Grief support for unhealthy outcome.
- (8) Parenting of a preterm infant.
- (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan for Behavioral Health.

78.27(1) Definitions.

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Care coordinator" means the professional who assists members in care coordination as described in paragraph 78.53(1) "b."

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Department*” means the Iowa department of human services.

“*Emergency*” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“*HCBS*” means home- and community-based services.

“*Integrated health home*” means the provision of services to enrolled members as described in subrule 78.53(1).

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. The designated case manager or integrated health home care coordinator shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department or the Iowa Plan for Behavioral Health contractor has approved the member’s plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS or in a treatment plan that has been authorized by the Iowa

Plan for Behavioral Health contractor shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

f. Iowa Plan for Behavioral Health eligibility. Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment plan have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written comprehensive

service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.
(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval.

(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.

(2) For members who are not Iowa Plan-eligible, services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) "e."

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;
- (10) Self-advocacy skills; or
- (11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member’s residence. Services shall not be provided in the member’s home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member’s home if the services are provided in an area apart from the member’s sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) Prevocational habilitation. “Prevocational habilitation” means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member’s comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in prevocational services.

78.27(10) Supported employment habilitation. “Supported employment habilitation” means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.

4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Assistance with time management.

6. Assistance with appropriate grooming.

7. Employment-related supportive contacts.

8. On-site vocational assessment after employment.

9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or “enclave” setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member’s job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member’s supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member’s comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department or the Iowa Plan for Behavioral Health contractor determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department or the Iowa Plan for Behavioral Health contractor will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights.

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)“d.”

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“*l.*”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“*f.*”

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)“*c.*”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“*c.*”

k. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)“*e.*”

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“*n.*”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“*g.*”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“*h.*”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“*i.*”

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“*j.*”

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)“*a.*”(4).

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“*b.*”

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“*d.*”

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“*e.*”

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“*f.*”

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“*g.*”

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*b.*”

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*d.*”

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*c.*”

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross-reference 78.14(7)“d”(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)“d”(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the

place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

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

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3) "b")

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11) “*b*,” the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11) “*a*,” prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(11) “*e*”); or
- (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, Mallory-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.
Physician's orders.
Laboratory reports.
Electrocardiogram reports.
History and physical examination.
Angiogram report, if applicable.
Operative report, if applicable.
Preadmission interview.
Exercise prescription.
Rehabilitation plan, including participant's goals.
Documentation for exercise sessions and progress notes.
Nurse's progress reports.
Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if

treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to

self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

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

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services.

78.33(1) Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

a. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

78.33(2) Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled

as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)“d.” The savings plan shall meet the requirements in paragraph 78.34(13)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides

services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) General service standards. All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a.* Observation and reporting of physical or emotional needs.
- b.* Helping a client with bath, shampoo, or oral hygiene.
- c.* Helping a client with toileting.
- d.* Helping a client in and out of bed and with ambulation.
- e.* Helping a client reestablish activities of daily living.
- f.* Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g.* Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin

care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) Mental health outreach. Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“*f*” and the skilled activities listed in paragraph 78.37(15)“*g*.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“*b*,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.

2. Chore service.

3. Consumer-directed attendant care (unskilled).

4. Home and vehicle modification.

5. Home-delivered meals.

6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)“b”(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)“b”(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)“b”(2) or the utilization adjustment factor in subparagraph 78.37(16)“b”(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.
 5. Be the least costly to meet the member's needs.
 6. Not be available through another source.
- e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:
- (1) The costs of the financial management service.
 - (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
 - (3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16) "d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 - (4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16) "d." The savings plan shall meet the requirements in paragraph 78.37(16) "f."
- f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.
- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living on-call service. The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service

component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.
 (2) Intravenous therapy administered by a registered nurse.
 (3) Parenteral injections required more than once a week.
 (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9) "b"(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,262 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.

a. *Activities to obtain a job.* Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or rehabilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) *Job development services.* Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) “f” and the skilled activities listed in paragraph 78.41(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
 - (2) During a search for employment by a usual caregiver,
 - (3) To allow for academic or vocational training of a usual caregiver,
 - (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
 - (5) Due to the death of a usual caregiver.
- b. Service requirements. Interim medical monitoring and treatment services shall:
- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
 - (2) Include comprehensive developmental care and any special services for a member with special needs; and
 - (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.
- c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.
- d. Limitations.
- (1) A maximum of 12 hours of service is available per day.
 - (2) Covered services do not include a complete nutritional regimen.
 - (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
 - (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
 - (5) The member-to-staff ratio shall not be more than six members to one staff person.
 - (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.
- e. A unit of service is 15 minutes.
- 78.41(10) Residential-based supported community living services.** Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.
- a. Allowable service components are the following:
- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
 - (2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
 - (3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
 - (4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Unit of service. Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. Exclusions.

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15) "b"(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)“b”(2) or the utilization adjustment factor in subparagraph 78.41(15)“b”(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member’s service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)“d.” The savings plan shall meet the requirements in paragraph 78.41(15)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “*a*” and “*b*” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the member’s employment needs. Second, the member’s interdisciplinary team must determine that the identified services are necessary. Third, the member’s case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member’s service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the member’s customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member’s

employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.
- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

- (3) A unit of service is 15 minutes.
- (4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.

- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)“f” and the skilled activities listed in paragraph 78.43(13)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)“d.” The savings plan shall meet the requirements in paragraph 78.43(15)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides

services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

1. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

- a.* The member is at least 17 years old.
- b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

- (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

- (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

- (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

- c.* The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

- d.* The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.

- (2) Bathing, shampooing, hygiene, and grooming.

- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.

- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

- (8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that

help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not

be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

- a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* Services must be billed in whole units.
- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c.* The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

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

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

- b. A unit of service is one modification or device.
- c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.
- d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.

- (5) Academic services.
- (6) General supervision and care.
- f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

- a. The goal of in-home family therapy is to maintain a cohesive family unit.
- b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.
- c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:
 - (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
 - (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
 - (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

- b. Care coordination, which means assisting members with:
 - (1) Medication adherence;
 - (2) Chronic disease management;
 - (3) Appointments, referral scheduling, and reminders; and
 - (4) Understanding health insurance coverage.
- c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:
 - (1) Supporting health management;
 - (2) Improving disease control; and
 - (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
 - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
 - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:
 - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
 - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
 - (3) Increasing health literacy and self-management skills; and
 - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
- f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

- a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:
 - (1) Has at least two chronic conditions;
 - (2) Has one chronic condition and is at risk of having a second chronic condition;
 - (3) Has a serious mental illness; or
 - (4) Has a serious emotional disturbance.
- b. For purposes of this rule, the term "chronic condition" means:
 - (1) A mental health disorder.
 - (2) A substance use disorder.
 - (3) Asthma.
 - (4) Diabetes.
 - (5) Heart disease.
 - (6) Being overweight, as evidenced by:
 - 1. Having a body mass index (BMI) over 25 for an adult, or
 - 2. Weighing over the 85th percentile for the pediatric population.
 - (7) Hypertension.
- c. For purposes of this rule, the term "serious mental illness" means:
 - (1) A psychotic disorder;
 - (2) Schizophrenia;
 - (3) Schizoaffective disorder;
 - (4) Major depression;
 - (5) Bipolar disorder;
 - (6) Delusional disorder; or
 - (7) Obsessive-compulsive disorder.
- d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders,

or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[ARC 0360C, IAB 10/3/12, effective 12/1/12]

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- ³ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.
- 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 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
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CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Substantial gainful activity*” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent’s(s’) income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse’s income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person’s income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical

emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “b” and 75.5(4) “c” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,765	\$950	\$3,365

(1) For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than \$505 is paid for home and vehicle modification services, the service worker or targeted case manager shall encumber up to \$505 per month within the monthly dollar cap allowed for the member until the total amount of the modification is reached within a 12-month period.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

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441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program

is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-4392, or service plan, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) "a" and "c" do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) "c"(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.
c. Service needs exceed the aggregate monthly costs established in 83.2(2) “*b*,” or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2) “*a*,” “*b*,” “*c*,” “*g*,” or “*h*” apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “*b*.”

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the service worker or targeted case manager.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “*a*” and “*b*.”
 [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“*Medical institution*” means a nursing facility which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

- a. Sixty-five years of age or older.
- b. A resident of the state of Iowa.
- c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.
2. Available and appropriate services to meet the consumer’s needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed

the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,765	\$1,339

- (3) The service plan must be completed before services are provided.
- (4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

- (1) Observable or measurable individual goals.
- (2) Interventions and supports needed to meet those goals.
- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
- (5) The desired individual outcomes.
- (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
- (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
- (8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:
 1. The name of the service provider responsible for providing the service.
 2. The funding source for the service.
 3. The amount of service that the consumer is to receive.
- (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.
- (10) The determination that the services authorized in the service plan are the least costly.
- (11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:
 1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
 2. The emergency backup support and crisis response system identified by the interdisciplinary team.
 3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.
[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility cannot precede the date the case manager signs the case plan.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.22(2) “b,” or are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) “b.”
- c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.
- d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The department service worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,840.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

441—83.43(249A) Application.

83.43(1) Application for HCBS AIDS/HIV waiver services. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) Approval of application.

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) Effective date of eligibility.

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermittent supported community living service” means supported community living service provided not more than 52 hours per month.

“Maintenance needs” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“*Organizational outcome*” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“*Outcome*” means an action or event that follows as a result or consequence of the provision of a service or support.

“*Procedures*” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified intellectual disability professional*” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“*Related condition*” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

(1) Be at least age 16.

- (2) Rescinded IAB 7/1/98, effective 7/1/98.
- (3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.
- (4) Not reside in a medical institution.
- h.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.
- i.* To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- j.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).
- k.* For residential-based supported community living services, meet all of the following additional criteria:
 - (1) Be less than 18 years of age.
 - (2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:
 - 1. Social history;
 - 2. Case history that includes previous placements and service programs;
 - 3. Medical history that includes major illnesses and current medications;
 - 4. Current psychological evaluations and consultations;
 - 5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
 - 6. Any current court orders in effect regarding the child;
 - 7. Any legal history;
 - 8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child’s current placement for services;
 - 9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
 - 10. Whether the interdisciplinary team is in agreement with the proposed placement.
 - (3) Either:
 - 1. Be residing in an ICF/ID;
 - 2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)“a”; or
 - 3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.
 - l.* For day habilitation, be 16 years of age or older.
 - m.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

- a.* Applicants currently receiving Medicaid case management or services of a department-qualified intellectual disability professional (QIDP) shall have the applicable coordinating staff and other interdisciplinary team members complete Form 470-4694, Case Management Comprehensive Assessment, and identify the applicant’s needs and desires as well as the availability and appropriateness of the services.

b. Applicants not receiving services as set forth in paragraph 83.61(2) “*a*” shall have a department service worker or case manager:

(1) Complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant’s needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-4694 or other circumstances beyond the worker’s control.

g. At initial enrollment, the service worker, department QIDP, case manager or Medicaid case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “*b*”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) HCBS intellectual disability waiver program limit. The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) Securing a payment slot. The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the

waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4)“b”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant’s need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker’s control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating the consumer’s choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member’s annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“*Adaptive*” means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Brain injury*” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.
 Malignant neoplasms of brain, frontal lobe.
 Malignant neoplasms of brain, temporal lobe.
 Malignant neoplasms of brain, parietal lobe.
 Malignant neoplasms of brain, occipital lobe.
 Malignant neoplasms of brain, ventricles.
 Malignant neoplasms of brain, cerebellum.
 Malignant neoplasms of brain, brain stem.
 Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
 Malignant neoplasms of brain, cerebral meninges.
 Malignant neoplasms of brain, cranial nerves.
 Secondary malignant neoplasm of brain.
 Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
 Benign neoplasm of brain and other parts of the nervous system, brain.
 Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
 Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
 Encephalitis, myelitis and encephalomyelitis.
 Intracranial and intraspinal abscess.
 Anoxic brain damage.
 Subarachnoid hemorrhage.
 Intracerebral hemorrhage.
 Other and unspecified intracranial hemorrhage.
 Occlusion and stenosis of precerebral arteries.
 Occlusion of cerebral arteries.
 Transient cerebral ischemia.
 Acute, but ill-defined, cerebrovascular disease.
 Other and ill-defined cerebrovascular diseases.
 Fracture of vault of skull.
 Fracture of base of skull.
 Other and unqualified skull fractures.
 Multiple fractures involving skull or face with other bones.
 Concussion.
 Cerebral laceration and contusion.
 Subarachnoid, subdural, and extradural hemorrhage following injury.
 Other and unspecified intracranial hemorrhage following injury.
 Intracranial injury of other and unspecified nature.
 Poisoning by drugs, medicinal and biological substances.
 Toxic effects of substances.
 Effects of external causes.
 Drowning and nonfatal submersion.
 Asphyxiation and strangulation.
 Child maltreatment syndrome.
 Adult maltreatment syndrome.
“Case management services” means those services established pursuant to Iowa Code chapter 225C.
“Child” means a person with a brain injury aged 17 years or under.
“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.
“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.
“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

“Service coordination” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“Service plan” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

83.82(2) Need for services.

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services using the following criteria:

- (1) The assessment shall be based, in part, on information provided to the IME medical services unit.
- (2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed \$2,954 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more

than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.

- (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a physical disability aged 18 years to 64 years.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Guardian” means a guardian appointed in probate court for an adult.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“Service plan” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

“Third-party payments” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“Waiver year” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$692 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney

for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) Annual assessment. The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.

- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN’S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, abilities, desires, and goals.

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a written, consumer-centered, outcome-based plan of services developed by the consumer’s interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant’s level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

83.122(4) Financial eligibility. The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

83.122(6) Need for service. The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$1,967 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level-of-care determinations and the consumer's service plan are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met;

b. Eligibility and level-of-care determinations have been made; and

c. The service plan has been completed.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review. Every 12 months, the local office shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

a. Continuing eligibility factors as specified in rule 441—83.122(249A).

b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall

terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) *Payment slot.* When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) *Termination.* A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.
- e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services shall apply as specified in 441—paragraphs 130.5(3) "a" and "b."

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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DIVISION C
WITHDRAWAL, DIVERSION AND STORAGE
OF WATER: WATER RIGHTS ALLOCATION

CHAPTER 50

SCOPE OF DIVISION—DEFINITIONS—FORMS—RULES OF PRACTICE

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—50.1(455B) Scope of division. The department has jurisdiction over the surface and groundwater of the state to establish and administer a comprehensive program to ensure that the water resources of the state be put to beneficial use to the fullest extent possible, that the waste or unreasonable use, or unreasonable methods of use of water be prevented, and that the conservation and protection of water resources be required with the view to their reasonable and beneficial use in the interest of the people.

Any person who proposes to pump or divert by gravity more than 25,000 gallons of water during a period of 24 hours or less from any source of groundwater or surface water, including streams bordering the state, impound surface water, divert surface runoff into a well, sinkhole or excavation or inject water or any material into a well has a duty to review the thresholds in Chapter 51 and contact the department to resolve any doubt concerning whether a permit is required.

Chapter 51 explains when approval is required for withdrawal, diversion or storage of water. Chapter 52 explains criteria for permitting withdrawal, diversion or storage of water. Chapter 53 sets forth the procedure for designating certain ground and surface water sources as protected sources and explains special criteria and conditions which may be applicable to those sources. Chapter 54 describes procedures and criteria for determining compensation to owners of nonregulated wells for well interference caused by permitted uses.

567—50.2(455B) Definitions. Definitions used in this division of these rules are listed in alphabetical order as follows:

“Adequate groundwater supply” means an aquifer which is capable of providing enough water to satisfy the demands which have been placed on it.

“Administrative resolution” means the settlement of well interference conflicts by the department according to established rules.

“Agricultural drainage well” means a vertical opening to an aquifer or permeable substratum which is constructed by any means including but not limited to drilling, driving, digging, boring, using an auger, jetting, washing, or coring, and which is capable of intercepting or receiving surface or subsurface drainage water from land directly or by a drainage system.

“Agricultural drainage well area” means an area of land where surface or subsurface water drains into an agricultural drainage well directly or through a drainage system connecting to the agricultural drainage well.

“Apparent well interference” means well interference in a nonregulated well resulting from a permitted use is likely but has not been verified.

“Aquifer” means a water-bearing geologic formation (soil or rock) of sufficient volume, porosity, and permeability to be capable of yielding a usable quantity of water to a well or spring.

“Bulletin No. 23” means Technical Bulletin No. 23 entitled “Guidelines for Well Interference Compensation,” March 1986.

“Certified well contractor” means a well contractor who has successfully passed an examination prescribed by the department to determine the applicant’s qualifications to perform well drilling or pump services or both pursuant to 567—Chapter 82.

“Community public water supply” means a system for the provision to the public of piped water for domestic use which has at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents.

“Compensation” means payment to the owner of a nonregulated well for damages caused by a lowered water level in the well due to withdrawal of water for a permitted use.

“Complainant” means the owner of a nonregulated well who is suspected of being or has been shown to be adversely affected by well interference.

“*Complaint*” means the formal allegation against a permitted water user who is suspected of causing well interference.

“*Confined aquifer*” means an aquifer which contains water under pressure overlain by impermeable formations such as clay or shale. In a well penetrating a confined aquifer, pressure will cause water to rise above the top of the aquifer. If the pressure in a confined aquifer is sufficiently great, water will rise above the ground surface and flow from a well, thus resulting in a “flowing artesian well” or a “naturally flowing well.”

“*Conflict*” means a dispute between a nonregulated well owner and a permitted water user regarding the liability of the permitted user for well interference damages to the nonregulated well.

“*Consumptive use*” means any use of water which involves substantial evaporation, transpiration, incorporation of water into a product or removal of water from a source without return thereto. Consumptive uses include, but are not limited to, irrigation, evaporative cooling, and flooding of wildlife areas by withdrawals or diversions from watercourses or aquifers.

“*Controlled aquifer test*” means a test, as approved by the department, for pumping from a well at a controlled rate for a specified duration while water levels are accurately measured at given frequencies in the pumping well and other nearby wells which use the same aquifer.

“*Designated agricultural drainage well area*” means an agricultural drainage well area in which there is located an anaerobic lagoon or earthen manure storage structure which requires a construction permit under 567—Chapter 65.

“*Domestic use*” means a use of water for human consumption and sanitation and public safety (fire protection).

“*Drainage system*” means tile lines, laterals, surface inlets, or other improvements which are constructed to facilitate the drainage of land.

“*Earthen storage structure*” means an earthen cavity, either covered or uncovered, including but not limited to an anaerobic lagoon or earthen manure storage basin which is used to store manure, sewage, wastewater, industrial waste, or other waste as regulated by the department of natural resources, if stored in a liquid or semiliquid state.

“*General crop*” means hay, corn, soybeans, oats, grain sorghum or wheat.

“*Industrial use*” means a use of water by manufacturing, processing, commercial, and other industrial facilities incidental to providing a product or a service; excluding domestic use, irrigation use, livestock use, nonindustrial power generation use, and recreational and aesthetic use. Examples include but are not limited to manufacturing, food processing, industrial cooling, excavation and processing of rock and gravel products, commercial laundries, cooling of perishables and electrical power generation other than for public consumption.

“*Informal negotiations*” means discussion between a complainant and permittee or applicant regarding settlement of a well interference conflict.

“*Informal settlement*” means a resolution of a well interference conflict by informal negotiations between a complainant and permittee or applicant without formal action by the department.

“*Irrigation use*” means a use of water which is artificially applied to land to aid the growing of general crops and specialty crops.

“*Livestock use*” means a use of water in the production of animals such as for drinking, sanitation and cooling.

“*Nonregulated well*” means a well used to supply water for a nonregulated use (a use of water less than 25,000 gallons per day which is not required to have a water use permit).

“*Permanent storage*” means the volume of water expressed in acre-feet which is stored upstream from a dam or in an impoundment up to the level of the principal outlet works of the structure.

“*Permitted use*” means a use of water in excess of 25,000 gallons per day which requires a water use permit pursuant to these rules and 567—Chapters 51 and 52 and Iowa Code chapter 455B, division III, part 4.

“*Pesticide*” means (1) any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating directly or indirectly any insects, rodents, nematodes, fungi, weeds, and other forms of plant or animal life or viruses, except viruses on or in living persons, which the secretary of

agriculture shall declare to be a pest; and (2) any substance intended for use as a plant growth regulator, defoliant, or desiccant.

“Power generation use” means a use of water incidental to the generation of electric power for distribution and sale to the public including process water (e.g., boiler makeup) and water for cooling purposes.

“Protected flow” means the *“established average minimum flow”* defined in Iowa Code section 455B.261.

“Protected source” means a surface water or groundwater source recognized by rule as needing special protection in order to ensure its long-term availability, in terms of either quality or quantity, or both, to preserve the public health and welfare.

“Recreational and aesthetic use” means a use of water which can be curtailed and is not essential for the preservation of life, the general welfare, or the state’s economic base. Examples include but are not limited to flooding of wildlife areas; filling of pools and fountains; nonessential cooling; car washing; street cleaning; washing of other exterior surfaces such as windows and walls; amusement park-type water rides; turf watering such as lawns, golf courses, and athletic fields; and watering of landscape plantings.

“Seven-day, 1-in-10 year low flow (7Q10)” means the minimum average flow expected to occur during a period of seven consecutive days which has an average recurrence interval of once in ten years. The 7Q10 may be calculated for specific seasonal periods of less than one year when appropriate.

“Specialty crop” means all other crops not listed as a general crop, including but not limited to melons, sod farm or seed corn.

“Stream” means a *“watercourse”* other than a lake as defined in Iowa Code section 455B.261.

“Stream bordering the state” means those reaches of the Missouri, Mississippi, Des Moines, and Big Sioux rivers that serve as a state boundary.

“Sufficient water supply” means a nonregulated well which is capable of providing enough water for the nonregulated use.

“Surface water” means water occurring on the surface of the ground.

“Surface water intake” means an artificial opening to a drain tile which drains into an agricultural drainage well, if the artificial opening allows surface water to enter the drain tile without filtration through the soil profile.

“Suspect permittee” means a party possessing a water use permit when the permitted use is suspected of causing well interference in a nonregulated well.

“Test pumping” means a controlled aquifer test for verification of well interference using the existing wells and pumping systems of the complainant and suspect permittee.

“Verified well interference” means well interference which has been proven by test pumping or with other substantial evidence to have caused or will cause a nonregulated well to be unable to maintain a sufficient water supply.

“Water use reduction plan” means a program that establishes numeric water reduction goals (e.g., percent or volume of water per day) on a short-term time frame through either voluntary or mandatory conservation regulatory requirements (e.g., plumbing codes, sprinkling ordinances, et al.) for each customer category (residential, commercial, industrial, landscape irrigation, agricultural, recreational, or other). Such a plan shall include a mechanism for evaluating the system’s unaccounted-for water (water audit or the equivalent). An industrial permittee water use reduction plan shall examine reduction of the use of water in heat transfer, use of water in materials transfer, use of water for washing, and use of water as an incorporated ingredient. Each customer category or use category should be evaluated by the permittee. The permittee will then determine how to meet the water reduction goals.

“Well interference” means the lowering of water level in a well caused by the withdrawal of water at another location (usually a nearby well).

[ARC 2053C, IAB 7/8/15, effective 8/12/15]

567—50.3(17A,455B) Forms for withdrawal, diversion or storage of water.

50.3(1) Application forms. The following application forms are currently in use:

Form 16: Application for a New Water Use Permit or to Modify an Existing Water Use Permit. 542-3106.

Form 18: Application for Permit to Store Water for Beneficial Use. 542-3109.

Form 20: Registration of Minor Nonrecurring Use of Water. 542-3112.

Form 542-1470: Water Supply Section Water Use Permit Renewal.

Form 542-1539: Application for Use of an Agricultural Drainage Well.

50.3(2) *Supplementary information forms.* The following forms are used to obtain additional information to supplement various types of applications:

Form 21: Survey of Land Owners and Occupants. 542-3113.

Form 22: Well Inventory Form. 542-3114.

Form 122: Water Well Inspection Report.

50.3(3) *Reporting form.* The following form is for reporting permitted activities:

Form 23: Report of Water Use by all Regulated Users. 542-3115.

567—50.4(17A,455B) How to request a permit.

50.4(1) *Application form.*

a. Application for approval of a new withdrawal, diversion or storage of water unrelated to the use of an agricultural drainage well. For withdrawals, diversions, or storage of water unrelated to the use of an agricultural drainage well, a request for a new permit as distinguished from modification or renewal of an existing permit shall be made on Form 16 (542-3106). An application form must be submitted by or on behalf of the owner, lessee, easement holder or option holder of the area where the water is to be withdrawn, diverted or stored, and used. An application must be accompanied by a map portraying the points of withdrawal or diversion and storage, and the land on which water is to be used oriented as to section, township, and range. One application normally will be adequate for all uses on contiguous tracts of land. Tracts of land involved in the same operation separated only by roads or railroads will be deemed contiguous tracts.

b. Application for diversion of water related to the use of an agricultural drainage well. An application for the diversion of water and any other materials to an aquifer related to the use of an agricultural drainage well shall be made on a form obtained from the department and be submitted by or on behalf of such owners, lessees, easement holders, or option holders of all lands within the agricultural drainage well area. If the agricultural drainage well is part of a legally organized drainage district, the drainage district shall be a joint applicant. Applications for permits for diversions related to the use of an agricultural drainage well that existed prior to February 18, 1998, shall be made by July 1, 1999, with the exception of agricultural drainage wells that must be closed to comply with the provisions of 1997 Iowa Acts, Senate File 473. An application will not have to be filed for wells in a designated agricultural drainage well area which must be closed by December 31, 1999. In addition, the department may grant up to a six-month delay in the application date for owners of agricultural drainage wells where it can be shown there is a reasonable expectation that the agricultural drainage well will be voluntarily closed by December 31, 1999.

c. Application for modification or renewal of a permit. A request for renewal of a permit should be submitted on Form 542-1470. A request to modify an existing permit shall be made on Form 16 (542-3106) and must include an explanation of the necessity for the modification.

d. Where to submit application. Rescinded IAB 6/7/06, effective 7/12/06.

50.4(2) *Fees.*

a. Application fee. An application to the department for a new permit, modification of an existing permit, or registration of a minor nonrecurring use of water must be accompanied with the fee listed in the table below. These fees are nonrefundable and are not transferable. For any single application, if more than one fee in the table below applies, only the higher fee is required. The fees become effective on July 1, 2009.

Application Description	Form	Fees, in dollars
(1) To apply for a new permit to withdraw or divert water	16 (542-3106)	\$350
(2) To renew an existing permit	542-1470	\$0
(3) To modify an existing permit to either add a new source or increase the amount or rate of water withdrawn or diverted from a source or sources	16 (542-3106)	\$350
(4) To modify the conditions of an existing permit which are not described in Item 3 of this table (see above)	16 (542-3106)	\$0
(5) To apply for an aquifer storage and recovery permit or a protected source designation	N/A	\$700
(6) To apply for a permit to store water	18 (542-3109)	\$75
(7) To register a minor nonrecurring use of water	20 (542-3112)	\$75

b. Annual permit fee. In addition to the application fee, there is an annual permit fee for a water use permit or an aquifer storage and recovery permit. The annual fee shall be based on the number of active permits. Each permit holder shall pay the same annual fee. The fee will not be prorated and is nonrefundable. The annual permit fee is due December 1 of each year, beginning with December 1, 2009. The department will provide an annual fee notice to each permittee at least 60 days prior to the fee due date. An additional fee of \$100 will be imposed if the fee is not received by December 1. Failure to remit the fee by January 1 may result in the cancellation of the permit.

(1) There is no annual fee for a water storage permit (see (6) of table, paragraph 50.4(2) “a”) or for a minor nonrecurring water use registration (see (7) of table, paragraph 50.4(2) “a”).

(2) The annual fee shall be based on the costs for administering the water use permitting program for the previous calendar year and on the budget for the next fiscal year. The department will review the annual permit fee each year and adjust the fee as necessary to cover all reasonable costs required to develop and administer the water use permitting program. Permit holders that have paid an application fee after December 1, but prior to November 30, will not be required to pay an annual fee until December 1 of the following year. If an applicant remits an annual fee for the 12-month period beginning December 1 and then later submits an application fee for a permit modification, the applicant will be refunded the lesser of the fees. The department shall request commission approval of the amount of the annual fee no later than September 30 of each year.

50.4(3) Supporting information required for complete application. An application shall not be considered complete until the fee specified in this rule and all supporting information requested under 567—50.6(17A,455B) have been submitted by the applicant or agents of the applicant.

[ARC 7694B, IAB 4/8/09, effective 5/13/09]

567—50.5(455B) Initial screening of applications.

50.5(1) General procedure. Each application upon receipt shall be promptly evaluated by the department to determine whether adequate information is available to review the project. The department shall then advise the applicant of additional information required to review the project.

50.5(2) Application to withdraw groundwater. Evaluation of the potential effects of a proposed withdrawal of groundwater requires review of available hydrogeological information. The department may require additional supporting hydrogeological information, which the applicant is responsible for providing.

567—50.6(17A,455B) Supporting information. Applicants shall submit supporting information which is reasonably required to assist the department in conducting the investigation of an application required by Iowa Code sections 455B.264 and 455B.281 and in determining whether granting of a permit would be consistent with the policies and principles of beneficial use set forth in Iowa Code section 455B.262. Certain supporting information requirements are described in this rule. This description is intended to identify frequently required information. The department may require additional information relative to the permit application.

50.6(1) Application for permit to withdraw groundwater.

a. Identification of source and effects of pumping. An applicant shall be required to submit information needed by the department to identify the aquifer(s) from which withdrawals of water are proposed, predict the effects of pumping with a reasonable degree of confidence, and determine any permit conditions for well interference pursuant to 567—Chapter 54. At many locations the only reliable methods to determine the availability of a water source of adequate quantity and quality and to predict the effects of pumping require test drilling, yield test pumping, and a controlled aquifer test with measurements in one or more observation wells conducted with prior approval in a manner that is acceptable to the department. The applicant shall be required to perform each of these exploratory operations to the extent necessary for the department to obtain information from which to determine whether a permit should be granted and to identify conditions which should be imposed in any permit granted. The following requirements apply to exploratory drilling and test pumping.

(1) Test drilling. In cases where test drilling is needed for geological information relevant to the application, the applicant is responsible for employing a driller who will collect, bag and properly label cutting samples at each five-foot interval and at each apparent change in geological formation from a test hole or production well hole at least the approximate depth of the proposed production well. The cutting samples must be saved for collection by the department in sample bags provided by the department's Iowa geological survey (IGS). The samples shall be accompanied by a driller's log showing the location and total depth of the hole and a description of the materials encountered at successive intervals.

(2) Yield testing. An applicant shall be required to construct a well and test pump it for yield to the extent necessary to determine whether water is available at the applicant's proposed rate of withdrawal from the proposed source. A written registration from the department is required before any yield test in which more than 25,000 gallons will be withdrawn in a period of 24 hours or less (see 567—subrule 51.6(5)).

(3) Controlled aquifer test with supervision. An applicant shall be required to conduct a controlled aquifer test with supervision by a certified well contractor, licensed professional engineer or other designee of the department as a condition of obtaining a water permit if the department finds an aquifer test necessary to determine the effects which the proposed withdrawal has on other water uses. The applicant may be required to construct, develop, and maintain adequate observation wells for use in an aquifer test and for subsequent water level measurements or water quality monitoring. An applicant shall be responsible for obtaining a registration for an aquifer test as provided in 567—subrule 51.6(5).

b. Cooperation in obtaining information about surrounding wells. An applicant who requests a permit authorizing withdrawals of groundwater from a well or reservoir may be required to assist the department in conducting an inventory of nearby wells within a designated radius of the proposed site. The need for an inventory and the appropriate radius will be determined after considering the known characteristics of the aquifer which the applicant proposes as a source of water and the rate and amount of the proposed withdrawals. The department shall provide a map specifying the area within which an inventory is proposed and forms specifying the information to be gathered in the inventory. The department shall also provide to the applicant a description of regulated uses within the inventory area. The applicant shall make a good faith effort to assist the department in obtaining available information from public records to identify landowners and occupants and from drilling contractors or pump installers identified by a landowner or occupant responding to the inventory.

50.6(2) Application for an irrigation permit. An applicant who proposes to irrigate crops on land which includes soils more erodible than Capability Subclass Iie as defined by the U.S.D.A. Natural Resources Conservation Service (NRCS), or slopes greater than 6 percent where a modern NRCS Soil Survey is not available, shall submit a soil conservation plan prepared with the assistance of the NRCS for the land in which crop irrigation is proposed. The plan shall be accompanied by the applicant's written explanation of how operation of the proposed irrigation system will be compatible with the conservation plan.

50.6(3) Application for permit to dewater a rock quarry. Iowa Code section 455B.268 and 567—Chapter 51 require that a permit be obtained before diverting water or material from the surface directly into any underground watercourse or basin. When the department investigates an application

for a permit to pump water for dewatering of a quarry excavated in carbonate rock, the department shall consider the potential for pollution of an underground watercourse or basin from drainage of surface water into the quarry. If available information, including topographic and subsurface geological information, supports a finding that drainage of surface water into the quarry would constitute a violation of the permit requirement in Iowa Code section 455B.268 and might cause pollution of an underground watercourse or basin if not controlled, then the department shall require that the applicant either request a permit to authorize a drainage of surface water into the quarry, or construct and maintain a means of controlling surface water which would otherwise drain into the quarry. Examples of suitable methods of controlling surface drainage are low berms or artificial drainage ways constructed as needed to reduce runoff of surface water from adjacent land into the quarry.

50.6(4) *Application for permit to divert water into an aquifer not related to the use of an agricultural drainage well.* An applicant for a permit to divert water or any other material from the surface into an aquifer not related to the use of an agricultural drainage well shall submit information showing that the requested diversion will not alter the quality of the aquifer.

50.6(5) *Application for uses that were nonregulated prior to July 1, 1985.* Rescinded IAB 6/7/06, effective 7/12/06.

50.6(6) *Applications for a permit to withdraw water from a protected water source.* An applicant for a permit to withdraw water from a protected water source designated in rule 567—53.7(455B) may be required to provide specific information to support the application as required by rule 567—53.5(455B) or rule 567—53.7(455B).

50.6(7) *Application for permit to divert water into an aquifer related to the use of an agricultural drainage well.* An applicant for a permit to divert water or any other material into an aquifer by means of an agricultural drainage well shall submit the following information. The locations of the features as listed below shall be shown on a map drawn to scale submitted with the application.

- a. Location of the agricultural drainage well to at least the nearest quarter-quarter section, township and range.
- b. Diameter and depth of the agricultural drainage well, if known.
- c. Description and ownership of the lands which are drained by the agricultural drainage well and the associated drainage system.
- d. Location of tiles which drain to the agricultural drainage well, if known, and the location of any existing surface water intakes.
- e. The location and description of any earthen storage structures, confinement feeding operations, or open feedlots within the agricultural drainage well area.
- f. Information regarding any known connections between the agricultural drainage well or its drainage system and wastewater disposal or storage systems such as septic tanks and the location of such connections.
- g. The nature and extent of any agreements between the well owner and adjacent landowners who have lands which are drained by the agricultural drainage well and associated tile drainage system.
- h. Any available information regarding the economic and physical feasibility of closing the agricultural drainage well.

567—50.7(17A,455B) Review of complete applications.

50.7(1) *Order of processing.* In general, complete applications including all requested supporting information shall be reviewed in the order that complete information is received. However, when there are a large number of pending applications, which precludes the department from promptly processing all applications, the department may expedite review of a particular application out of order if the completed application and supporting documents were submitted at the earliest practicable time and any of the following conditions exist:

- a. Relatively little staff review time (generally less than four hours) is required and delay will cause the applicant hardship;
- b. The applicant can demonstrate that a delay in the permit will result in a substantial cost increase of a large project;

c. Prompt review of the permit would result in earlier completion of a project that conveys a significant public benefit;

d. The need for a permit is the result of an unforeseen emergency or catastrophic event; or

e. A permit is needed to complete a project that will abate or prevent an imminent threat to the public health and welfare.

50.7(2) Summary report of application review. Before an initial decision is issued on an application, personnel assigned to review an application shall prepare a summary report which shall state whether the withdrawal, diversion, or use of water as described in the complete application conforms to relevant criteria. The report shall identify the information used to determine the potential for a proposed use of water to adversely affect other water users. For an application to withdraw groundwater, the report shall describe the effects on water levels anticipated to occur from the proposed use; indicate if verified well interference has been found; and provide options for resolving any verified well interference in accordance with 567—Chapter 54.

50.7(3) Public notice of recommendation to issue permit.

a. *New permits and modifications of permits.*

(1) Applicable to all except community public water supplies. Before issuance of a permit to withdraw, divert or inject water, the department shall publish notice of recommendation to grant a permit. The notice shall summarize the application and the recommendations in the summary report. The notice shall allow 20 days to request a copy of the summary report and submit comments on the report. The department may extend the comment period upon request for good cause. The notice shall be published in a newspaper circulated in the locality of the proposed water source. The notice shall be sent to any person who has requested a copy of the notice concerning the particular water use under consideration.

(2) Applicable only to community public water supplies. Prior to the issuance of a permit to withdraw, divert or inject water to a community public water supply, the department shall publish a notice of recommendation to grant a permit. The notice shall allow 20 days to request a copy of the summary report and submit comments on the report. The department may extend the comment period upon request for good cause. The notice shall include a brief summary of the proposed permit and shall be published in a newspaper of general circulation within the county of the proposed water source as provided in Iowa Code section 618.3. If the newspaper of general circulation is not the newspaper of the nearest locality to the proposed water source that publishes a newspaper, the notice shall also be published in the newspaper of the nearest locality to the proposed water source that publishes a newspaper, and the department may charge the applicant for the expenses associated with publishing the notice in the second newspaper. The notice shall be sent to any person who has requested a copy of the notice concerning the particular water use under consideration.

b. *Permit renewals.* The notice provisions of paragraph “a” of this subrule shall apply to requests for permit renewals except that the department need not publish notice of recommendation to grant a renewal permit which does not involve modification of permit conditions.

50.7(4) Notice to the applicant that proposed withdrawal, diversion or use of water does not conform to criteria. If the application review discloses that the proposed withdrawal, diversion or use of water violates one or more criteria and the application should therefore be disapproved, or approved only subject to special conditions to which the applicant has not agreed, the department shall notify the applicant and, when practical, suggest appropriate project modifications. The department shall offer the applicant an opportunity to submit comments before an initial decision is made.

50.7(5) Applications for uses that were nonregulated prior to July 1, 1985. Rescinded IAB 6/7/06, effective 7/12/06.

567—50.8(17A,455B) Initial decision by the department.

50.8(1) Form of decision. The initial decision on an application shall be a permit or disapproval issued by the department. Each permit shall include appropriate standard and special conditions consistent with Iowa Code sections 455B.261 to 455B.274 and 455B.281 and 567—Chapters 52 to 54. The decision may incorporate by reference and attachment the summary report described in 50.7(2). Each decision shall include the following:

- a. Determinations as to whether the project satisfies all relevant criteria not addressed in an attached summary report.
- b. An explanation of the purpose for imposing each special condition.
- c. Explanation of consideration given to all comments submitted pursuant to 50.7(3) and 50.7(4) unless the comments are adequately addressed in the attached summary report.

50.8(2) Notice of initial decision. Copies of the initial decision shall be mailed to the applicant, any person who commented pursuant to 50.7(3), and any other person who has requested a copy of the decision. The decision shall be accompanied by a certification of the date of mailing. An initial decision becomes the final decision of the department unless a timely notice of appeal is filed in accordance with 567—50.9(17A,455B). The final decision may be filed with the appropriate county recorder to give constructive notice to future landowners of any conditions or requirements imposed by the final decision.

567—50.9(17A,455B) Appeal of initial decision. Any person aggrieved by an initial decision issued under 567—50.8(17A,455B) may file a notice of appeal with the director. The notice of appeal must be filed within 30 days following the certified date of mailing of the decision unless the appellant shows good cause for failure to receive actual notice and file within the allowed time. The form of the notice of appeal and appeal procedures are governed by 567—Chapter 7. The department shall mail a copy of the notice of appeal to each person who commented on the application. If the appeal is from denial of a permit and a notice of recommendation to grant a permit was not published, the department shall publish the notice of commencement of a contested case and provide an opportunity for interested people to seek intervention in the contested case.

These rules are intended to implement Iowa Code sections 17A.3, 455B.105, 455B.171, 455B.262, 455B.264 to 455B.274, 455B.278, and 455B.281 and chapter 460.

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¹ At its meeting held 2/9/98, the Administrative Rules Review Committee delayed 50.2, eight definitions, 50.3(1), 50.4, 50.6(4), 50.6(7), 50.7(2), 50.7(4) and 50.8(2) until adjournment of the 1998 Session of the General Assembly.

CHAPTER 52
CRITERIA AND CONDITIONS FOR AUTHORIZING WITHDRAWAL,
DIVERSION AND STORAGE OF WATER
[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—52.1(455B) Scope of chapter. This chapter contains criteria for issuance of water permits, permit conditions, and conditions under which the department may modify, cancel, or suspend permits. This chapter includes special criteria applicable to particular types of water uses such as irrigation and criteria applicable to particular types of sources of water such as surface waters and groundwater sources.

567—52.2(455B) Conditions on permitted water uses. This rule includes permit restrictions which apply to various types of permitted water uses. A permitted use may be subject to additional restrictions related to its potential effects on surface or groundwater. Requirements and restrictions which relate to particular types of water sources are found in rules 567—52.3(455B), 567—52.4(455B), 567—52.6(455B), 567—53.6(455B) and 567—53.7(455B). Procedures for determining conditions imposed due to well interference are found in rule 567—54.7(455B).

52.2(1) Irrigation permits.

a. Authorized irrigation season. Permits shall authorize irrigation of any general crop from April 1 to September 30 and any specialty crop from April 1 to October 31 unless the department finds that a different period is justified.

b. Authorized annual amount. Permits shall authorize withdrawals equivalent to 1 acre-foot per acre for a general crop and 2 acre-feet per acre for a specialty crop unless the department finds that a different amount is justified. Factors to be considered in determining whether a different amount is justified include soil types and potential water availability during drought events. Notwithstanding the general criteria in this paragraph, permits for irrigation of general crops from the alluvial aquifers of the Missouri and Mississippi Rivers shall authorize withdrawals of up to 1.5 acre-feet per acre if requested by the applicant unless the department finds that a different amount is justified.

c. Conservation plan for erosion control. When 567—subrule 50.6(2) requires that an applicant for an irrigation permit submit a soil conservation plan, any permit granted to the applicant shall make authorization of irrigation contingent upon compliance with the soil conservation plan.

d. Irrigation scheduling. The department may require that irrigation of a general crop be scheduled according to a method recommended by the department to minimize the potential for waste of water or by an equivalent method selected by the permittee and approved by the department.

e. Irrigation system check valve. Each irrigation permit shall require the permittee to install an adequate check valve and conduct frequent inspections for the proper functioning of the check valve to prevent back-siphoning of contaminants into the water source before a fertilizer, pesticide, herbicide, or other additive is introduced into the irrigation system.

52.2(2) The amount of water authorized for industrial use or power generation use shall be consistent with industrywide usage for the same or similar purposes and types of facilities and shall provide for growth where need is demonstrated by the applicant.

52.2(3) The amount of water authorized for use by a community public water supply shall not exceed 200 gallons per day per capita except additional water may be provided for growth and industrial use where need is demonstrated by the applicant.

52.2(4) Recreational and aesthetic permits.

a. Authorized amount. The amount of water authorized for recreational and aesthetic uses shall be determined on a case-by-case basis.

b. Watering system backflow-prevention valve. Each permit authorizing the use of water for turf or landscape plantings shall require the permittee to install an adequate check valve and conduct frequent inspections for the proper functioning of the check valve to prevent back-siphoning of contaminants into the water source before a fertilizer, pesticide, herbicide or other additive is introduced into the irrigation system.

This rule is intended to implement Iowa Code section 455B.265.

567—52.3(455B) Conditions on withdrawals from streams.

52.3(1) Streams draining less than 50 square miles. Withdrawals of water from streams draining less than 50 square miles shall be subject to the following conditions:

a. Two hundred gallon per minute (200 gpm) restriction. New withdrawals of water for consumptive uses shall not be in excess of 200 gallons per minute (200 gpm) on an aggregate basis. However, the department may authorize withdrawals in excess of 200 gallons per minute (200 gpm) for storage purposes during high stream flows, taking into account other permitted withdrawals on the stream reach.

b. Protected flow restriction. Except as provided in 52.3(1)“c,” withdrawals for consumptive uses, with the exception of community public water supplies, shall cease when the stream flow is below the protected flow designated in rule 567—52.8(455B). When the flow of a stream, or portion thereof designated by the department, is below a flow equal to the protected flow plus the summation of all permitted consumptive withdrawals by permittees whose permits provide for maintenance of a protected flow in such stream or portion thereof, the department may, subject to the provisions of 52.3(1)“c,” order temporary cessation or rotation of all consumptive withdrawals, with the exception of community public water supplies, to ensure that the protected flow is preserved.

c. Replacement water exemption. Paragraphs 52.3(1)“a” and “b” shall not apply to withdrawals for consumptive uses from a stream if the permittee discharges replacement water into such stream at rates sufficient to offset the consumptive withdrawals and the department approves the method and location of discharge.

d. Exemption until July 1, 1991, for certain users. Rescinded IAB 6/7/06, effective 7/12/06.

52.3(2) Streams draining 50 or more square miles. Withdrawals of water from streams draining 50 or more square miles shall be subject to the following conditions:

a. Protected flow restriction. Except as provided in 52.3(2)“b,” withdrawals for consumptive uses, with the exception of community public water supplies, shall cease when the stream flow is below the protected flow designated in rule 567—52.8(455B). When the flow of a stream, or portion thereof designated by the department, is below a flow equal to the protected flow plus the summation of all permitted consumptive withdrawals by permittees whose permits provide for maintenance of a protected flow in said stream or portion thereof, the department may, subject to the provisions of 52.3(2)“b,” order temporary cessation or rotation of all consumptive withdrawals, with the exception of community public water supplies, to ensure that the protected flow is preserved.

b. Replacement water exemption. Paragraph 52.3(2)“a” shall not apply to withdrawals for consumptive uses from a stream if the permittee discharges replacement water into such stream or tributary thereto at rates sufficient to offset the consumptive withdrawals and the department approves the method and location of discharge.

c. Exemption until January 1, 1989, for certain water uses. Rescinded IAB 6/7/06, effective 7/12/06.

d. Exemption after December 31, 1988, for certain electric generating facility cooling needs. Rescinded IAB 6/7/06, effective 7/12/06.

e. Exemption until July 1, 1991, for certain users. Rescinded IAB 6/7/06, effective 7/12/06.

567—52.4(455B) Conditions on withdrawals from groundwater sources.

52.4(1) Withdrawals from unconfined aquifers adjacent to streams draining less than 50 square miles. Withdrawals of water from unconfined aquifers adjacent to streams draining less than 50 square miles shall be subject to the following conditions:

a. Two hundred gallon per minute (200 gpm) restriction. New withdrawals for a consumptive use at any location within ¼ mile (1320 feet) of a stream shall not be in excess of 200 gallons per minute (200 gpm), except when the applicant can conclusively demonstrate by conducting appropriate tests that withdrawals in excess of 200 gallons per minute (200 gpm) will not reduce the flow of the stream. However, the department may authorize withdrawals in excess of 200 gallons per minute (200 gpm) for storage purposes during high stream flows.

b. Protected flow restriction. Except as provided in 52.4(1)“c” and 52.4(1)“e,” withdrawals for consumptive uses, with the exception of community public water supplies, at any point within 1/8 mile (660 feet) of a stream shall be considered withdrawals from the stream and shall cease when the stream is below the protected flow designated in rule 567—52.8(455B), unless the applicant or permittee can conclusively demonstrate by conducting appropriate tests that the withdrawal will not reduce the flow of the stream.

c. Border stream-interior stream confluence restriction. Withdrawals for consumptive uses, with the exception of community public water supplies, from the alluvial aquifers below the floodplains of streams bordering the state at any point within 1/8 mile (660 feet) of any interior stream shall cease when the flow of such interior stream is at or below the seven-day, one-in-ten year (7Q10) low flow, except as provided in 52.4(1)“d.”

d. Other conditions. Notwithstanding 52.4(1)“a” to 52.4(1)“c,” other conditions may be imposed that are necessary to ensure adequate protection of water supplies for ordinary household, livestock, and domestic uses, for fish and wildlife, for recreational use, for the preservation and enhancement of aesthetic values, and for other uses of a public nature.

e. Replacement water exemption. Paragraphs 52.4(1)“a” to 52.4(1)“c” shall not apply to withdrawals for consumptive uses from an unconfined aquifer if the permittee discharges replacement water into such stream or tributary thereto at rates sufficient to offset the consumptive withdrawals and the department approves the method and location of discharge.

f. Exemption until July 1, 1991, for certain users. Rescinded IAB 6/7/06, effective 7/12/06.

52.4(2) Withdrawals from unconfined aquifers adjacent to streams draining 50 or more square miles. Withdrawals of water from unconfined aquifers adjacent to streams draining 50 or more square miles shall be subject to the following conditions:

a. Protected flow restriction. Withdrawals for consumptive uses, with the exception of community public water supplies, at any point within 1/8 mile (660 feet) of a stream shall be considered withdrawals from the stream and shall cease when the stream is below the protected flow designated in rule 567—52.8(455B), except as provided in 52.4(2)“c” to 52.4(2)“f.”

b. Seven-day, one-in-ten-year low flow restriction. Withdrawals for consumptive uses, with the exception of community public water supplies, at any point located between 1/8 mile (660 feet) and ¼ mile (1320 feet) of a stream, other than a stream bordering the state, shall cease when the stream flow is at or below the seven-day, one-in-ten-year low flow (7Q10), except as provided in 52.4(2)“c” to 52.4(2)“f.”

c. Border stream-interior stream confluence restriction. Withdrawals for consumptive uses, with the exception of community public water supplies, from the alluvial aquifers below the floodplains of streams bordering the state at any point within 1/8 mile (660 feet) of any interior stream shall cease when the flow of such interior stream is at or below the seven-day, one-in-ten-year (7Q10) low flow, except as provided in 52.4(2)“d.”

d. Other conditions. Notwithstanding 52.4(2)“a” to 52.4(2)“c,” other conditions may be imposed if they are necessary to ensure adequate protection of water supplies for ordinary household, livestock, and domestic uses, for fish and wildlife, for recreational use, for the preservation and the enhancement of aesthetic values, and for other uses of a public nature.

e. Replacement water exemption. Paragraphs 52.4(2)“a” to 52.4(2)“c” shall not apply to withdrawals for consumptive uses from an unconfined aquifer, if the permittee discharges replacement water into such stream or tributary thereto at rates sufficient to offset the consumptive withdrawals and the department approves the method and location of discharge.

f. Exemptions from low flow restrictions. The restrictions of 52.4(2)“a” to 52.4(2)“d” may be waived if the applicant or permittee can conclusively demonstrate by conducting tests to demonstrate that the withdrawal will not reduce the flow of the adjacent stream. The plan for testing must be approved by the department prior to the applicant’s or permittee’s conducting the tests.

g. Exemption until July 1, 1991, for certain users. Rescinded IAB 6/7/06, effective 7/12/06.

52.4(3) Withdrawals from the Cambrian-Ordovician (Jordan) aquifer. Withdrawals of water from the Cambrian-Ordovician (Jordan) aquifer, including the St. Peter sandstone formation, the Prairie du Chien group and the Jordan sandstone formation, shall be subject to the following conditions:

a. Two-hundred-gallon-per-minute restriction on irrigation, recreational, or aesthetic uses. New withdrawals of water for irrigation, recreational, or aesthetic uses shall not be in excess of 200 gallons per minute. Existing permits for irrigation, recreational and aesthetic uses that authorize withdrawal rates in excess of 200 gallons per minute may be modified or rescinded by the department if, as determined by the department, any well in the vicinity experiences loss of water due to pumping or if the pumping water level is reduced to or below the levels described in paragraphs “f” and “g” of this subrule.

b. Two-thousand-gallon-per-minute restriction on industrial or power generation uses. New withdrawals of water for industrial or power generation uses at one plant location shall not exceed 2,000 gallons per minute. Existing permits for industrial or power generation use that authorize withdrawal rates in excess of 2,000 gallons per minute may be modified or rescinded by the department if any well in the vicinity experiences loss of water due to pumping or if the pumping water level is reduced to or below the levels described in paragraphs “f” and “g” of this subrule.

c. Limited cooling and geothermal use. No once-through (single pass with disposal to storm sewer or equivalent) cooling water or geothermal usage is allowed. Withdrawals for geothermal purposes are prohibited unless 100 percent of the withdrawn water is reinjected into the aquifer in accordance with the requirements of the department.

d. Jordan aquifer high-capacity permits and wells. Water use permits for the Jordan aquifer shall be issued on a five-year permit cycle. The water use permit for wells expected to pump over 25,000 gallons per day from the Jordan aquifer must be obtained from the department before any water well construction permit is issued. After the water use permit has been obtained, the county may issue a Cambrian-Ordovician (Jordan) aquifer water well construction permit for any nonpublic water supply system unless that well is located in one of the protected-source areas listed in 567—subrules 53.7(2) and 53.7(3). The department may issue a Cambrian-Ordovician (Jordan) aquifer water well construction permit for a public water supply system or a well located in the protected source areas listed in 567—subrules 53.7(2) and 53.7(3). All driller’s logs for water use wells completed in the Jordan aquifer shall be submitted to the department and the Iowa Geological Survey.

e. Tier 1 Jordan wells. A Jordan water use well is classified as Tier 1 when pumping water levels have not reached Tier 2 or Tier 3 levels described in paragraphs “f” and “g” of this subrule. Permittees with Tier 1 Jordan wells shall follow standard water use reporting procedures for the Jordan aquifer pursuant to rule 567—52.6(455B).

f. Tier 2 Jordan wells. A Jordan well is classified as Tier 2 when the pumping water level measured at the well declines over 300 feet below the 1978 Horick and Steinhilber potentiometric surface or the pumping water level declines over 50 percent from the 1978 Horick and Steinhilber potentiometric surface and the top of the Jordan aquifer, whichever is more conservative. Permittees with Tier 2 wells shall comply with paragraph “h” of this subrule.

g. Tier 3 Jordan wells. A Jordan well is classified as Tier 3 when the pumping water level measured at the well declines over 400 feet below the 1978 Horick and Steinhilber potentiometric surface or the pumping water level declines over 75 percent from the 1978 Horick and Steinhilber potentiometric surface and the top of the Jordan aquifer, whichever is more conservative. Permittees with Tier 3 wells shall comply with paragraph “i” of this subrule.

h. Site-specific water use reduction plan for Tier 2 Jordan wells. Permittees with Jordan wells that have reached the Tier 2 level pursuant to paragraph “f” of this subrule shall develop a water use reduction plan and submit the plan to the department. The plan must be reviewed and approved by the department. The water use reduction plan shall set a defined usage percent reduction target that will minimize Jordan aquifer withdrawals and prevent the decline of the water level from reaching the Tier 3 category pursuant to paragraph “g” of this subrule. Guidance for writing and implementing water use reduction plans is available in paragraph “k” of this subrule. If the water use reduction plan is not implemented, the department may reduce the permitted water use allocation, pursue enforcement of the permit, or rescind the permit.

i. Enhanced site-specific water use reduction plan and predictive model for Tier 3 Jordan wells. Permittees with Jordan wells that have reached the Tier 3 level pursuant to paragraph “g” of this subrule shall develop an aggressive water use reduction plan using an approved predictive model that will lead to recovery of the pumping water level to elevations above Tier 3 levels. The plan and model predictions shall be reviewed and approved by the department. If water levels continue to decline beyond the Tier 3 level, the department may reduce the permitted water use allocation, pursue enforcement of the permit including aspects of the water use reduction plan, or rescind the permit.

j. Variances. Variances from the restrictions imposed by these rules will be considered by the department through the procedures found in rule 567—50.9(455B) and in 561—Chapter 10.

k. Resources for developing water use reduction plans. The resources suggested by and available from the department as guidance for developing water use reduction plans are listed in paragraph 52.9(3) “d.”

52.4(4) Withdrawals from the Dakota Sandstone formation of the Cretaceous system. The department may issue permits authorizing withdrawals of water from the Dakota Sandstone formation of the Cretaceous system for all beneficial uses under the following conditions:

a. Inventory of nearby wells by applicant. An applicant who requests authorization for withdrawals of water at a maximum rate in excess of 200 gallons per minute shall conduct and submit an inventory of nearby wells as described in 567—paragraph 50.6(1) “b.”

b. Observation wells. In addition to the requirement of 52.6(3) for construction of an access port to allow measurement of water levels in each production well, an applicant or permittee may also be required to construct, maintain, and monitor observation wells as a condition of obtaining or keeping a water permit if the department, after consultation with the department’s IGS, finds observation wells necessary to monitor the effects of the proposed or authorized withdrawals of water. Observation wells must be properly constructed and responsive to water level fluctuations in the aquifer. Plans for and monitoring of the observation wells must be approved by the department.

c. Prohibition of excessive water level declines. If the department, after consultation with the department’s IGS, determines that withdrawals of water from the Dakota Sandstone formation of the Cretaceous system within a designated geographical area are causing water level declines which constitute a significant threat to the public interest in the availability of water for sustained beneficial use of the aquifer, renewals of permits shall be denied, and permits shall be modified or canceled in accordance with procedures in Iowa Code section 455B.271, as necessary to protect the aquifer for sustained use.

d. Priorities in renewal, modification and cancellation of permits. If permit renewals must be denied or if permits must be modified or canceled to prevent or abate water level declines which constitute a significant threat to the public interest in the availability of water for sustained beneficial use of the aquifer, withdrawals of water for community public water supplies shall have priority over withdrawals of water for other regulated uses. The priority list for water use can be found in 52.10(3).

This rule is intended to implement Iowa Code sections 455B.261, 455B.264, 455B.266, 455B.271 and 455B.272.

[ARC 2053C, IAB 7/8/15, effective 8/12/15]

567—52.5(455B) Duration of permits for withdrawal or diversion of water.

52.5(1) General. A permit granted shall remain as an appurtenance of the land described in the permit through the date specified in the permit and any extension of the permit or until an earlier date when the permit or its extension is canceled under 567—52.7(455B). Upon application for a permit prior to the termination date specified in the permit, a permit may be renewed by the department.

52.5(2) Permits for withdrawal or diversion of surface water. Permits for withdrawal or diversion of surface water shall be issued for ten years.

52.5(3) Permits for withdrawal of groundwater. Permits for withdrawal of groundwater shall be issued for a maximum period of ten years and may be granted for less than ten years if geological data on the capacity of the aquifer and the rate of its recharge are indeterminate.

This rule is intended to implement Iowa Code section 455B.265.

567—52.6(455B) Monitoring, recording and reporting of water use and effects on water source.

52.6(1) *Water use reports.* Each permittee shall submit to the department, at least annually, as prescribed by the department, reports of water used, diverted, or stored and any other information deemed necessary by the department.

52.6(2) Reserved.

52.6(3) *Requirement of access port for measurement of water levels in a regulated well.* All new water permits which authorize withdrawals from wells shall require that each authorized production well be equipped with an access port having a minimum diameter of $\frac{3}{4}$ inch. The access port must be located to allow insertion of a steel tape or electric probe into the well casing for measurement of water levels.

52.6(4) *Aquifer tests and observation wells.* A permittee may be required to conduct a controlled aquifer test as a condition of keeping a water permit if the department, after consultation with the department's IGS, finds an aquifer test to be necessary to determine the effects which the authorized withdrawals have on other water uses. A controlled aquifer test, authorized by the department and supervised by a certified well contractor, licensed professional engineer or other designee of the department, may be required for an administrative resolution of a well interference conflict pursuant to 567—Chapter 54. The permittee may be required to construct, develop, and maintain adequate observation wells for use in an aquifer test and for subsequent water level measurements or water quality monitoring.

This rule is intended to implement Iowa Code sections 455B.261, 455B.264, 455B.266, 455B.268(1) and 455B.281.

567—52.7(455B) Modification, cancellation, and emergency suspension of permits.

52.7(1) *General.* Except as provided in subrule 52.7(2), after at least 30 days' written notice mailed to the permittee's last-known address by certified mail and an opportunity for the permittee to be heard in an evidentiary hearing conducted according to the contested case provisions of Iowa Code chapter 17A, the department may modify or cancel a water permit or any condition of a permit, notwithstanding any other rule, for any of the following:

a. Breach of permit condition or law. A condition of the permit has been breached or the law pertaining to the permit has been violated by the permittee or permittee's agent, tenant, or consultant.

b. Nonuse. The permittee has failed for three consecutive years to use the water, and the permittee has not demonstrated adequate plans to use water within a reasonable time. Nonuse due to adequate rainfall shall not be a justification for cancellation of a permit. However, authorization to withdraw water from a proposed well may be canceled after notice to the permittee if the permittee has failed to construct the proposed well within three years after issuance of the permit.

c. Public health and safety. Modification or cancellation is necessary to protect the public health and safety, to protect the public interests in lands and waters, or to prevent any manner of substantial injury to persons or property.

d. Addition of conservation provisions. Modification to include conservation provisions is deemed necessary by the department.

e. Allocated amount. For three consecutive years, annual water use has exceeded the amount of water allocated in the permit.

52.7(2) *Emergency suspension or restriction.* Notwithstanding any other rule or permit conditions, if the department finds that it is imperatively necessary in an emergency to protect from imminent danger or substantial injury the public health, welfare or safety, the public or private interest in lands or water, or to implement the priority allocation system pursuant to rule 567—52.10(455B), and these findings are incorporated into a written emergency order to the permittee, then the department may immediately suspend or restrict operations under a permit and require the permittee to take measures necessary to prevent or remedy the injury. The emergency order shall state an effective date appropriate to the situation which invoked the suspension or restriction and shall be immediately effective on that date unless stayed, modified, or vacated at a hearing before the commission or by the court. The emergency order shall

remain in effect until a date specified in the order, unless the order is revoked or the expiration date modified, due to a change in the situation giving rise to the order or a decision following appeal.

This rule is intended to implement Iowa Code sections 455B.271, 455B.272 and 17A.3.

567—52.8(455B) Designated protected flows of streams.

52.8(1) Purpose. The protected flow is designed to protect and maintain adequate water supplies for ordinary household and livestock use; for fish and wildlife use; for recreational use; for in-stream wasteload assimilation and pollution control; for beneficial water use needs in the watershed; for preservation of aesthetic values; and for other uses of a public nature.

52.8(2) Protected flow basis. The protected flow is based in part on statistical information contained in “Low-Flow Characteristics of Iowa Streams,” (INRC Bulletin No. 9 (1958)), “Low-Flow Characteristics of Iowa Streams through 1966,” (INRC Bulletin No. 10 (1970)), “Annual and Seasonal Low-Flow Characteristics of Iowa Streams,” (INRC Bulletin No. 13 (1976)), and “Statistical Summaries of Selected Iowa Streamflow Data Through September 1996, U.S. Geological Survey Open-File Report 98-176 (1998).”

52.8(3) Protected flow levels.

a. At stream gaging stations. The protected flow, expressed in cubic feet per second (cfs) at points on a stream with an official U.S. Geological Survey stream flow gage are listed in the table below.

The Protected Flow at U.S.G.S.
Stream Gaging Locations

River or Stream	Gage Location	Protected Low Flow (CFS)
Beaver Creek	New Hartford	18
Big Creek	Mount Pleasant	2
Black Hawk Creek	Hudson	4.5
Boone River	Webster City	24
Boyer River	Logan	41
Cedar River	Conesville	1240
Cedar River	Cedar Rapids	937
Cedar River	Waterloo	710
Cedar River	Janesville	185
Cedar River	Charles City	100
Chariton River	Rathbun	2.9
Des Moines River	Keosauqua	350
Des Moines River	Ottumwa	300
Des Moines River	Tracy	300
Des Moines River	Des Moines (14th St.)	300
Des Moines River	Saylorville	200
Des Moines River	Stratford	310
Des Moines River	Fort Dodge	220
East Fork Des Moines River	Dakota City	42
East Nishnabotna River	Red Oak	37
East Nishnabotna River	Atlantic	18
Floyd River	James	22
Iowa River	Wapello	1390
Iowa River	Lone Tree	150

River or Stream	Gage Location	Protected Low Flow (CFS)
Iowa River	Iowa City	150
Iowa River	Marengo	204
Iowa River	Marshalltown	104
Iowa River	Rowan	21
Little Cedar River	Ionia	28
Little Sioux River	Turin	200
Little Sioux River	Correctionville	106
Little Sioux River	Linn Grove	42
Maple River	Mapleton	50
Maquoketa River	Maquoketa	372
Middle Raccoon River	Panora	20
Middle River	Indianola	14.6
Monona-Harrison Ditch	Turin	27
Nishnabotna	Hamburg	128
Nodaway	Clarinda	15
North Raccoon River	Jefferson	82
North Raccoon River	Sac City	14
North River	Norwalk	5.6
North Skunk River	Sigourney	35
Raccoon River	Van Meter	190
Rock River	Rock Valley	26
Shell Rock River	Shell Rock	147
Skunk River	Augusta	287
Soldier River	Pisgah	20
South Raccoon River	Redfield	58
South River	Ackworth	4.1
South Skunk River	Oskaloosa	94
South Skunk River	Ames (below Squaw Creek)	23
South Skunk River	Ames	4.8
Thompson River	Davis City	13
Turkey River	Garber	210
Upper Iowa River	Decorah	80
Walnut Creek	Hartwick	2
Wapsipinicon River	DeWitt	150
Wapsipinicon River	Independence	17
West Fork Cedar River	Finchford	66
West Fork Ditch	Hornick	12
West Nishnabotna River	Randolph	67
West Nishnabotna River	Hancock	49
White Breast Creek	Dallas	3.2
Winnebago River	Mason City	39

b. At stream locations other than gaging stations. The protected flow for points on a stream, other than at a U.S. Geological Survey gaging station, shall be established, as the need arises, by comparison of available stream flow data and basin characteristics.

This rule is intended to implement Iowa Code sections 455B.261, 455B.262 and 455B.267.

567—52.9(455B) Water conservation.

52.9(1) General. The purpose of water conservation requirements is to preserve the availability of water which is withdrawn for use, as opposed to protected flow provisions in rules 567—52.3(455B), 567—52.4(455B), and 567—52.8(455B) which preserve in stream flows.

Each permit granted after July 1, 1986, including any permit granted to a community public water supply, will include conditions requiring routine (day-to-day) conservation practices and requiring emergency conservation practices after notification by the department. Existing permits may be modified to include conservation conditions pursuant to 52.7(1)“d,” if deemed necessary by the department.

Only general provisions for routine conservation will be included in a permit, unless water is to be withdrawn from a protected water source designated in 567—Chapter 53 which has specific requirements for routine conservation. Permit conditions requiring routine conservation are primarily intended to raise awareness of water usage, develop a preparedness for periods of water shortages, and minimize waste of water.

General conditions involving emergency conservation will be included in all permits. Specific emergency conservation conditions may be included in a water use permit pursuant to subrule 52.9(2). If specific emergency conservation permit conditions are required, they will be based on a water conservation plan developed by the permittee or applicant, in accordance with subrule 52.9(3), and approved by the department.

The purpose of emergency conservation is to minimize consumptive use of water from a source experiencing a temporary shortage. Emergency conservation restrictions will be imposed only when water shortages are imminent or actually exist, in accordance with rule 567—52.10(455B). Long-term water shortages may be dealt with in the protected source rules, 567—Chapter 53.

52.9(2) Applicability of emergency conservation. Specific emergency conservation requirements may be made a condition of a water withdrawal permit if the proposed or permitted withdrawal could result in a significant consumptive use of water from a source which is likely to experience a short-term shortage.

Specific emergency conservation requirements will not normally be included in a water use permit under any of the following conditions:

a. The proposed or existing permitted water use involves a consumptive use of less than 25,000 gallons per day from any water source during periods of substantial water shortage.

b. The proposed or permitted use is subject to protected stream flow conditions pursuant to rules 567—52.3(455B), 567—52.4(455B), and 567—52.8(455B).

c. The water source for the proposed or permitted use is from a surface water impoundment or purchased storage owned by the applicant or permittee.

d. The proposed or permitted use is unable to conserve water without substantially disrupting or ceasing an essential activity which requires water, such as operating a steam electric generating plant, watering livestock, or operating a commercial laundry.

e. The proposed or permitted withdrawal is from a source of water which is not likely to experience a substantial short-term water shortage including, but not limited to, the Missouri and Mississippi Rivers and adjacent alluvial aquifers, the Jordan Sandstone Aquifer, and the Iowa Great Lakes.

f. The source of water is or will be utilized by only the permitted or proposed water user and withdrawal from the source for the permitted or proposed use has no potential for affecting other water uses.

52.9(3) Water conservation plans. Unless specific emergency conservation permit conditions are not required in accordance with subrule 52.9(2), the applicant or permittee shall submit a water conservation plan with an application for a new water use permit or renewal of an existing permit. The department

may also require a water conservation plan to be submitted by any existing permittee after a minimum of 90 days' notice. If an applicant is in doubt as to whether or not the application requires a water conservation plan, the department should be contacted and provided with a description of the proposed source of water, intended use, and desired amount and rate of withdrawal. The department will then make a determination of whether or not a conservation plan is necessary. If a water conservation plan is required with an application for permit renewal, the department will notify the permittee at least 120 days prior to expiration of the permit.

Water conservation plans shall describe the measures to be used to achieve water conservation and estimate water savings from each measure. Water conservation plans must contain the following information, as applicable, to be approved by the department.

a. General provisions. The following information shall be included in all water conservation plans:

- (1) A description of each source of water withdrawal (i.e., well or surface water intake) including the location, well depth, pumping rate, and date of installation.
- (2) A description of wastewater discharge including the location and discharge frequency.
- (3) Monthly withdrawal amounts from each source for the past five years.
- (4) Monthly total water withdrawal amount for the past five years.
- (5) Monthly total wastewater discharge amount for the past five years.
- (6) A quarterly breakdown, by the water use categories in subrule 52.10(3), of total water use and estimated consumptive water use over the past five years.
- (7) A description of any previous water shortage problems, including the cause, frequency, other affected parties, and how they were resolved.
- (8) Identification of nearby water supplies which are potentially affected by or could potentially affect the proposed or permitted withdrawal.
- (9) A means of identifying impending water shortage problems (e.g., water level in wells or a reservoir decline to a certain level or stream flows fall to a certain rate).

b. Routine conservation provisions. Consideration of routine conservation is encouraged although it is not normally required in a water conservation plan. Documented water savings from routine conservation measures will be credited towards emergency conservation requirements. Suggested routine conservation measures include:

- (1) Use of water-saving plumbing devices or required use of these devices in building codes.
- (2) Scheduling irrigation to minimize peak water use.
- (3) Use of efficient irrigation techniques.
- (4) Implementing programs to minimize lost water, such as distribution system leaks.
- (5) Use of metered water billing by public water supplies.
- (6) Utilizing best commercially available technology to optimize efficiency of water use.
- (7) Implementing recycling and reuse practices.
- (8) Developing alternative water sources which are not susceptible or are less susceptible to shortages.
- (9) Increasing rates charged for water or eliminating reduced rates for large users.

c. Emergency conservation provisions. Water conservation plans shall contain emergency conservation provisions in accordance with the following criteria.

- (1) General. The consumptive nature of a water use, as described in subrule 52.9(2) and determined from information required in 52.9(3) "a," shall be reduced by at least 50 percent over similar periods of normal use. This criterion does not apply to irrigation use. If this requirement cannot be met, justification for nonattainment shall be provided which must include documentation that an activity involving water use is essential and demonstration of use of best commercially available technology. The department may then grant variances on a case-by-case basis.

Measures which will be credited for emergency conservation include, but are not limited to, the following: documented water savings resulting from routine water conservation measures; shutdown, postponement, or curtailment of nonessential activities involving water use; switching to nonaffected sources for water supply; mitigation of consumptive uses by direct discharge of stored water or

water from a nonaffected source to the affected water source; acquisition and retirement of existing consumptive uses from the affected water source (credit for retirement of existing consumptive uses will be given only for the amount authorized during periods when emergency conservation is required); and imposing surcharges on water use during periods of shortage.

(2) Public water supplies. At a minimum, emergency water conservation plans for public water supplies must include provisions for restricting outside, consumptive water use.

(3) Irrigation water use. Emergency water conservation plans for irrigation water uses shall limit irrigation water use to the equivalent of one inch per irrigated acre per week for general crops and specialty crops, unless the water conservation plan contains other mitigating provisions such as those listed in 52.9(3)“c”(1) above.

Water conservation plans shall also address irrigation scheduling. Irrigation scheduling should attempt to provide approximately equal water use on each day of an irrigation cycle. Irrigation scheduling may be done in cooperation with other nearby irrigators who utilize the same water source.

d. Resources for water conservation and water use reduction planning.

(1) The following resources are suggested by and available from the department as guidance for the development of water conservation plans and water use reduction plans:

1. “Water Wise—Efficiency Planning and Water Conservation Plan Workbook for Water and Wastewater Utilities,” Iowa Association of Municipal Utilities, 2013 (available online through the department’s Web site).

2. “Water Conservation Programs—A Planning Manual,” Manual of Water Supply Practices M52, American Water Works Association, 2006.

3. “Handbook of Water Use and Conservation,” Amy Vickers, Waterplow Press, Amherst, Massachusetts, 2001.

(2) Water conservation plans and water use reduction plans shall comply with the standards of the American Water Works Association or a reasonable equivalent as determined by the department.

This rule is intended to implement Iowa Code sections 455B.262 and 455B.265.

[ARC 2053C, IAB 7/8/15, effective 8/12/15]

567—52.10(455B) Priority allocation restrictions.

52.10(1) General. After any event described in subrule 52.10(2) has occurred, the department will investigate and, if appropriate, may restrict water use according to the priority allocation plan as described in subrule 52.10(3). Prior to imposing the priority allocation plan, the department will normally require emergency conservation measures to be taken by existing permittees. The department will not normally require emergency conservation until a shortage of water is imminent and will not normally impose the priority allocation plan until an actual impairment of water usage exists.

The department will notify existing permittees of any emergency restriction or suspension of water use by written order pursuant to subrule 52.7(2). A permittee will be required to maintain daily records of water withdrawal and wastewater discharge, if any, while the emergency order is in effect. These records shall be available for inspection by the department to verify compliance with the order.

Suspension or restriction of water usage applicable to otherwise nonregulated water users shall be by emergency order of the director which the department shall cause to be published in local newspapers of general circulation and broadcast by local media. The emergency order shall state an effective date of the suspension or restriction and shall be immediately effective on that date unless stayed, modified or vacated at a hearing before the commission or by a court.

The department will lift the suspension or restriction of water usage, as deemed appropriate, when evidence of sustained, improved conditions is available.

The department will not impose a suspension of water or a further restriction, other than emergency conservation, on the uses of water provided in paragraphs 52.10(3)“g” through “i” or on uses of water pursuant to a contract with the state as provided in Iowa Code subsections 455B.263(5) and 455B.263(6) unless the governor has issued a proclamation, as described in paragraph 52.10(2)“b.” Notwithstanding such proclamation, in the case of water use under a contract with the state pursuant to

Iowa Code subsections 455B.263(5) and 455B.263(6) and in effect prior to March 5, 1985, restriction or suspension measures will be limited to emergency conservation.

52.10(2) Triggering events. The department may implement the priority allocation plan following the occurrence of any of the following:

- a. Receipt of a petition by a governmental subdivision or 25 persons that the priority allocation plan be implemented due to a substantial local water shortage adversely affecting their water supply.
- b. Issuance by the governor of a proclamation of a disaster emergency due to a drought or other event affecting water resources of the state.
- c. Determination by the department in conjunction with the homeland security and emergency management division of the Iowa department of public defense of a local crisis which affects availability of water.
- d. Receipt of information from a state or federal natural resource, research or climatological agency (including the National Drought Monitor) indicating that a drought of local or state magnitude is imminent. As a general guideline, emergency conservation or priority allocation restrictions will not be imposed on withdrawals from a surface stream or adjacent alluvial aquifer when stream flow is above the seven-day, one-in-ten-year low-flow level.

52.10(3) Priority allocation plan. Notwithstanding a person's possession of a permit or the person's use of water being a nonregulated use, the department may suspend or restrict usage of water by category of use on a local or statewide basis in the following order:

- a. Water conveyed across state boundaries.
 - b. Water used primarily for recreational or aesthetic purposes.
 - c. Uses of water for the irrigation of any general crop.
 - d. Uses of water for the irrigation of any specialty crop.
 - e. Uses of water for manufacturing or other industrial processes.
 - f. Uses of water for generation of electrical power for public consumption.
 - g. Uses of water for livestock production.
 - h. Uses of water for human consumption and sanitation supplied by rural water districts, municipal water systems, or other public water supplies.
 - i. Uses of water for human consumption and sanitation supplied by a private water supply.
- This rule is intended to implement Iowa Code section 455B.266.

567—52.11(455B) Plugging of abandoned wells. When authorization for withdrawals of water from a well expires without renewal, the permittee shall be responsible for plugging the well in accordance with Iowa Code section 455B.190, 567—Chapter 39, and Iowa Geological Survey Public Information Circular #1, "Well Plugging Procedures," or by an alternate method approved by the department for prevention of groundwater pollution. Form 542-1226 (Abandoned Water Well Plugging Record) must be completed and submitted as specified on the form. However, the department shall grant a variance from the requirement that the well be plugged if the permittee demonstrates an intent to maintain the well as a source of water for a nonregulated use or if the department determines that the well should be maintained as an observation well.

This rule is intended to implement Iowa Code sections 455B.262 to 455B.279(2).

567—52.12 to 52.19 Reserved.

567—52.20(455B) Water storage permits.

52.20(1) Beneficial use and protected flow criteria. A permit for storage of impounded water shall be based on the following findings:

- a. The proposed storage is for a specified beneficial use such as human or livestock water supply, recreation, aesthetic value, erosion control, or low-flow augmentation.
- b. The impounding structure can be operated in a manner which will not adversely affect any applicable protected flow in the impounded stream.

c. The construction, operation, and maintenance of the impounding structure has been approved by the department.

52.20(2) *Duration of permit.* A permit for storage of water impounded by a dam other than a major structure may be granted for the life of the structure. A permit for storage of water impounded by a major structure may be granted for any period not exceeding ten years.

52.20(3) *Conditions of approval for storage of water impounded by a major structure.* A permit authorizing storage of water impounded by a major structure as defined in 567—Chapter 70 shall include the following conditions:

a. Storage of water shall not commence until construction of the dam as approved by the department is completed and accepted by the department pursuant to 567—paragraph 74.21(1)“c.” Until construction of the dam is accepted the gate on the low level or dewatering outlet shall remain open.

b. The permittee shall notify the department of any proposed change in the ownership of any part of the dam, or of any change in the identity of the person responsible for its construction, operation, and maintenance. For dams built under easement where the property owner does not have primary responsibility for construction, operation, and maintenance, notice of proposed change in ownership is not required if the identity of the responsible person does not change.

c. The permittee shall permit inspections of the dam in accordance with 567—Chapter 74.

52.20(4) *Criteria for renewal of water storage permits.* In addition to considering the criteria in subrule 52.9(1), the department shall review its most recent dam safety inspection report as part of the review of an application for renewal of a water storage permit and shall consider the following additional factors:

a. The physical condition of the dam and appurtenant structures as related to safety of the dam.

b. The permittee’s record of compliance with the conditions of the expiring storage permit and the approval order which authorized construction, use and maintenance of the dam.

c. Changed circumstances including upstream or downstream development which may affect the hazard classification of the dam or its ability to function as intended.

52.20(5) *Conditions of cancellation or suspension of water storage permits.* When a water storage permit is canceled or suspended pursuant to Iowa Code section 455B.271, the gate on the low level or dewatering outlet shall be opened and the impoundment drained in accordance with the procedures in 567—Chapter 74 and the impoundment shall remain drained unless storage of water is again authorized. Additional measures including breaching of the dam may be required if necessary to reduce risk of damage associated with dam failure.

This rule is intended to implement Iowa Code sections 455B.262, 455B.264, 455B.265, 455B.267, 455B.270, 455B.271, 455B.274 and 455B.278.

567—52.21(455B) Permits to divert water to an agricultural drainage well.

52.21(1) *Approval criteria.* An application for a permit to divert water or other material to an aquifer by means of an agricultural drainage well shall not be approved if the agricultural drainage well is located within a designated agricultural drainage well area or the drainage well is to be constructed after February 18, 1998. An initial permit for the diversion of water or any material to an aquifer by means of an agricultural drainage well shall be based on a finding that the following criteria are satisfied. Renewal of such a permit shall be made only upon a finding that such owners, lessees, easement holders, or option holders are in compliance with the conditions of the initial permit or any permit issued thereafter and that the agricultural drainage well meets applicable approval criteria, including paragraph 52.21(1)“c.”

a. The application for the permit has been submitted by or on behalf of all owners, lessees, easement holders, or option holders of all lands which are drained by the agricultural drainage well.

b. There is reasonable assurance that the applicant(s) can minimize the contamination potential to the aquifer through closure of surface water intakes, elimination of any septic system connections, and other appropriate management practices including nutrient and pesticide management as required under subrule 52.21(2).

c. There are no economically and physically viable alternatives to the use of the agricultural drainage well. The department will consult with the division of soil conservation, department of agriculture and land stewardship, and other parties with drainage expertise as necessary to determine if viable alternatives exist. In determining whether a viable alternative exists, the department will consider all relevant factors, including the following:

(1) The impact that closure of the ADW would have on lands drained by the agricultural drainage well if an alternative drainage system is not provided.

(2) The cost and feasibility of providing an alternative outlet. Alternative drainage systems constructed under the provisions of the alternative drainage system assistance program administered by the division of soil conservation will be considered as a viable alternative to the use of the agricultural drainage well.

(3) The availability of public assistance for the construction of an alternate outlet or for compensation for loss of productivity on lands drained by the agricultural drainage well.

(4) The results of the engineering study provided for under 52.21(2)“l.”

52.21(2) Approval conditions. Permits granted for the diversion of water or any material to an aquifer by means of an agricultural drainage well shall be subject to the following conditions as appropriate.

a. *Surface water intakes.* All surface water intakes shall be removed by December 31, 2001. Additional tile lines may be added to compensate for removal of surface water intakes provided the replacement tile does not increase the size of the agricultural drainage well area. Replacement tiles shall generally conform with the Natural Resources Conservation Services Tile Intake Replacement Interim Standard 980.

b. *Cisterns.* Cisterns shall be sealed or otherwise modified as necessary by December 31, 2001, to prevent direct entry of surface water. Compliance with the Natural Resources Conservation Services Wellhead Protection Interim Standard 981 will be considered as complying with this condition. Alternatives to the interim standard may be allowed with department approval.

c. *Access/ventilation.* The agricultural drainage well or its cistern shall be provided with a locked cover to prevent unauthorized access. If the agricultural drainage well and the related drainage system is ventilated, ventilation shall be accomplished in a manner that will not allow surface water to enter the agricultural drainage well.

d. *Repair and maintenance.* The agricultural drainage well and the associated drainage system may be repaired and maintained as needed to maintain drainage efficiency. The drainage well and associated tile drainage system shall be maintained in a condition so as to prevent surface water which has not filtered through the soil profile from entering the drainage well.

e. *Modifications of drainage well.* The agricultural drainage well shall not be modified without department approval. The related drainage system may be modified without department approval providing the modifications do not enlarge the agricultural drainage well area. Construction of new surface water intakes is not allowed.

f. *Closure.* If the permittee discontinues use of the agricultural drainage well, the department shall be notified and closure shall be made in accordance with 567—Chapter 39 or by an alternative method approved by the department. The permit will be revoked upon submission of proof that the drainage well was properly closed.

g. *Modification or cancellation of permit.* As provided in 567—52.7(455B), the department may modify or cancel the permit or require the permittee to take other actions to protect the public health and safety, to protect the public interest in lands and waters, or to prevent any manner of substantial injury to persons or property.

h. *Waste systems.* Effluent from wastewater treatment or storage systems, including on-site wastewater treatment and disposal systems such as septic systems, shall not be allowed to directly enter the agricultural drainage well or associated tile drainage system. Runoff controls consistent with Chapter 65 requirements and guidance may be required for feedlots that discharge across lands drained by an agricultural drainage well to control manure nitrogen and to eliminate the potential for direct entry of animal wastes into an agricultural drainage well or its drainage system.

i. Nitrogen management. The application of nitrogen from all sources, including manure, legumes, and commercial fertilizers, on lands within an agricultural drainage well drainage area shall not exceed the nitrogen use levels necessary to obtain optimum crop yields for the crop being grown.

j. Application of liquid animal wastes. Application of liquid animal waste to lands drained by the agricultural drainage well shall be done in a manner that will not result in a discharge of the waste to the drainage well or associated drainage system.

k. Application of pesticides. The application of pesticides on lands within the agricultural drainage well area shall be in accordance with the provisions of Iowa Code chapter 206 and rules adopted pursuant to chapter 206.

l. Alternatives to the use of the agricultural drainage well. Prior to reissuance of a permit for the continued use of an agricultural drainage well, the permittee(s) shall conduct an engineering study of the physical and economic feasibility of alternatives to the continued use of the agricultural drainage well. The study shall comply with the provisions of Iowa Code chapter 542B regarding certification by a licensed professional engineer. The results of the study shall be submitted to the department at least one year prior to a request to renew a permit.

52.21(3) Closure of existing agricultural drainage wells.

a. Agricultural drainage wells within a designated agricultural drainage well area. A permit shall not be granted for the diversion of water or other material into an aquifer by means of an agricultural drainage well if the drainage well is located within a designated agricultural drainage well area. All existing agricultural drainage wells within a designated agricultural drainage well area shall be closed by December 31, 1999. Closure shall be in accordance with 567—Chapter 39, Requirements for properly plugging abandoned wells, or by an alternative method approved by the department. Cisterns shall be filled in or removed and filled in with earth or other suitable material and any tile lines shall be removed for a distance of 10 feet around the wellhead or, alternatively, be replaced with nonperforated pipe. The owner of the land on which the agricultural drainage well is located shall provide the department with notice that the well has been closed in accordance with the requirements of this paragraph. Agricultural drainage wells that have been properly closed will no longer be considered an agricultural drainage well by the department.

b. Other agricultural drainage wells. Existing agricultural drainage wells that have not been authorized by permit by December 31, 1999, shall be closed by that date unless the department has granted a waiver to the closure requirements. The closure procedures shall be as specified in 52.21(3)“a.”

This rule is intended to implement Iowa Code Supplement chapter 455I.

[Filed 10/9/75, Notice 8/25/75—published 10/20/75, effective 11/24/75]

[Filed emergency 6/24/77—published 7/13/77, effective 6/24/77]

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[Filed emergency 8/4/78—published 8/23/78, effective 8/4/78]

[Filed 9/14/78, Notice 7/12/78—published 10/4/78, effective 11 /8/78]

[Filed 11/5/80, Notice 9/17/80—published 11/26/80, effective 12/31/80]

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[Filed 2/24/82, Notice 11/11/81—published 3/17/82, effective 4/21/82]

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[Filed 10/2/87, Notice 6/17/87—published 10/21/87, effective 11/25/87]

[Filed 12/19/97, Notice 9/10/97—published 1/14/98, effective 2/18/98]¹

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Filed 5/17/06, Notice 3/15/06—published 6/7/06, effective 7/12/06]

[Filed ARC 2053C (Notice ARC 1914C, IAB 3/18/15), IAB 7/8/15, effective 8/12/15]

- ¹ At its meeting held February 9, 1998, the Administrative Rules Review Committee delayed 52.5 and 52.21 until the adjournment of the 1998 Session of the General Assembly.

CHAPTER 53
PROTECTED WATER SOURCES — PURPOSES — DESIGNATION PROCEDURES —
INFORMATION IN WITHDRAWAL APPLICATIONS — LIMITATIONS —
LIST OF PROTECTED SOURCES

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—53.1(455B) Scope of chapter. This chapter describes the purpose and procedures for designating specific surface water and groundwater sources as protected sources. This includes the special information that may be required of applicants for permits to withdraw water from such sources and conditions that may be applied to approved permits. Those protected sources so designated by rule are also listed.

This rule is intended to implement Iowa Code sections 455B.262, 455B.264 through 455B.274 and 455B.278.

567—53.2(455B) Designation of protected sources. The department, after consultation with the department's Iowa geological survey (IGS) and other authorities, may designate a surface water or groundwater source within a defined geographical area as a protected source.

Notwithstanding rules 567—53.3(455B) to 567—53.7(455B), the department may impose permit conditions on a case-by-case basis as it determines necessary to protect water resources of the state.

This rule is intended to implement Iowa Code sections 455B.262, 455B.264 through 455B.274 and 455B.278.

567—53.3(455B) Purposes of designating a protected source. The general purpose of designating a specific water source as a protected source is to ensure long-term availability in terms of quantity and quality to preserve public health and welfare. Specific purposes include but are not limited to the following:

53.3(1) To preserve the availability of the protected source for sustained beneficial use.

53.3(2) To prevent or minimize the movement of groundwater contaminants.

53.3(3) To maintain the surface water quality within a specific stream segment in order to meet state or federal standards, to preserve protected flows, or to maintain its availability for other beneficial use.

53.3(4) To preserve the protected flows in a stream which is hydraulically connected to a protected aquifer.

This rule is intended to implement Iowa Code section 455B.262.

567—53.4(455B) Designation procedure. The procedure for designation of a protected source shall be a rule-making proceeding to amend the list of protected sources in rule 567—53.7(455B). In addition to the requirements of rule 561—5.1(17A), as adopted by reference in 567—Chapter 5, an interested person who petitions the department to designate a protected water source may also be required to provide further supporting information including, but not limited to:

53.4(1) Facts and arguments demonstrating that existing rules and the opportunity for public participation in the application review and decision-making procedures of rules 567—50.7(17A,455B) to 567—50.9(17A,455B) are inadequate to ensure the long-term availability of the source and to preserve the public health and welfare.

53.4(2) Predictive geohydrological and chemical analyses of the groundwater source if the basis of the petition is to prevent or minimize the movement of known or suspected contaminants.

53.4(3) Facts and arguments demonstrating the effect that additional withdrawals from a stream or stream segment proposed for designation would have on downstream discharges, surrounding alluvial systems, natural biological systems, and potential changes in the frequency at which the protected stream discharge levels are reached.

This rule is intended to implement Iowa Code sections 455B.262, 455B.264 through 455B.274 and 455B.278.

567—53.5(455B) Information requirements for applications to withdraw water from protected sources. An applicant proposing to withdraw water from a protected source, as listed in rule 567—53.7(455B), may be required to submit information necessary for the department to determine the effects resulting from such withdrawal.

53.5(1) *Withdrawals from protected groundwater sources.* Applicants for permits may be required to provide that information detailed in rule 567—50.7(17A,455B) and additional predictive geohydrological and chemical analyses of the groundwater source. Where there is potential for a known contaminant to migrate, predictive analyses may also be requested to show potential movement and effects of the withdrawal on the piezometric head. Monitoring may be required in a permit authorizing withdrawals from a protected groundwater source.

53.5(2) *Withdrawals from protected surface water sources.* Applicants for permits may be required to demonstrate the effect of proposed withdrawals on downstream discharges, surrounding alluvial systems, natural biological systems, and potential changes in the frequency at which protected stream discharge levels are reached for any stream or stream reaches listed in rule 567—53.7(455B).

This rule is intended to implement Iowa Code sections 455B.262, 455B.264 through 455B.274 and 455B.278.

567—53.6(455B) Conditions in permits for withdrawals of water from a protected source. The designation of a protected water source in rule 567—53.7(455B) may include listing of special conditions on issuance of permits for withdrawals of water from the designated source. The designation may also include guidelines for imposition of special limitations on withdrawals authorized by permits which were in force on the effective date of the protected source designation. However, such guidelines may be enforced only in accordance with the procedures in rule 567—52.7(455B) for modification, cancellation and emergency suspension of permits, or after a permittee has had an opportunity to contest the imposition of proposed special limitations in permit renewal proceedings. When a group of permits is potentially affected by guidelines in rule 567—53.7(455B), hearings under rule 567—52.7(455B) may be consolidated.

53.6(1) *Withdrawals from streams or associated alluvium that are protected sources.* The department may apply special conditions on all permits for withdrawals from streams and associated alluvial systems that are protected water sources as listed in rule 567—53.7(455B). Such conditions may include cessation of withdrawals at a stream discharge rate to be determined by the department which may be in excess of the level required by 567—subrule 52.8(3). These restrictions may apply to both consumptive and nonconsumptive withdrawals.

53.6(2) *Withdrawals from groundwater sources that are protected sources.* The department may apply special conditions on all permits for withdrawals from groundwater systems that are protected water sources as listed in rule 567—53.7(455B). Such conditions may include immediate cessation of withdrawals if declines in piezometric levels or movement of known contaminants in the source are detected. These restrictions may apply to both consumptive and nonconsumptive withdrawals.

567—53.7(455B) List of protected water sources. The following list identifies water sources designated as protected sources under this chapter. Each listing includes the name of the surface water or groundwater source designated, the geographical areas affected, the specific purposes for designating the source, and special limitations imposed or recommended to achieve the purpose of the protected source designation. The listing may also include any special monitoring requirements and may specify a date by which the department must review the designation of the protected source.

53.7(1) *Ralston Site, Linn County.* The area within a one-mile radius of a point which is 600 feet south of the midpoint of the northern edge of Section 2, Township 83 North, Range 7 West in Linn County is a protected water source. Any new application for a permit to withdraw groundwater or to increase an existing permitted withdrawal of groundwater from within the protected water source area will be restricted or denied, if necessary to preserve public health and welfare or to minimize movement of groundwater contaminants from the Ralston Site. The Ralston Site is identified in the Registry of Hazardous Waste or Hazardous Substance Disposal Sites pursuant to Iowa Code section 455B.426.

Withdrawal of groundwater from within the protected water source area may also be restricted or denied from what would otherwise be nonregulated wells, if necessary to preserve public health and welfare or to minimize movement of groundwater contaminants from the Ralston Site. The Linn County health department will refer any application for a construction permit for a private well within the protected water source area to the department's water supply section that will, after consultation with the department's IGS, determine whether the proposed well will be allowed.

53.7(2) Cambrian-Ordovician (Jordan) aquifer in Johnson and Linn Counties.

a. Geographical area. The protected water source area includes portions of Johnson and Linn Counties. The actual geographical boundaries of the area are defined in subparagraph 53.7(2) "a"(3).

(1) New or modified water use permits. Any new application for a permit to withdraw groundwater or to increase an existing permitted withdrawal of groundwater from the Cambrian-Ordovician (Jordan) aquifer within the protected water source area will be restricted or denied if necessary to preserve public health and welfare.

(2) Withdrawal of groundwater. Withdrawal of groundwater from within the protected water source area may also be restricted or denied from water supply wells constructed in the Cambrian-Ordovician (Jordan) aquifer, public or private, and the construction of all new water supply wells in the Cambrian-Ordovician (Jordan) aquifer shall be restricted or denied, if necessary, to preserve public health and welfare or to minimize adverse effects to the "available" head (i.e., the original pressure head above the top of the aquifer). The Johnson County and Linn County health departments are not authorized to issue a construction permit for a private well drilled into or through the Cambrian-Ordovician (Jordan) aquifer within the protected water source area without the approval of the department. The department's water supply engineering section will determine whether the proposed well can be constructed and may require that the well meet public water well standards.

(3) Map of protected water source area. The department shall maintain a map of the protected water source area.

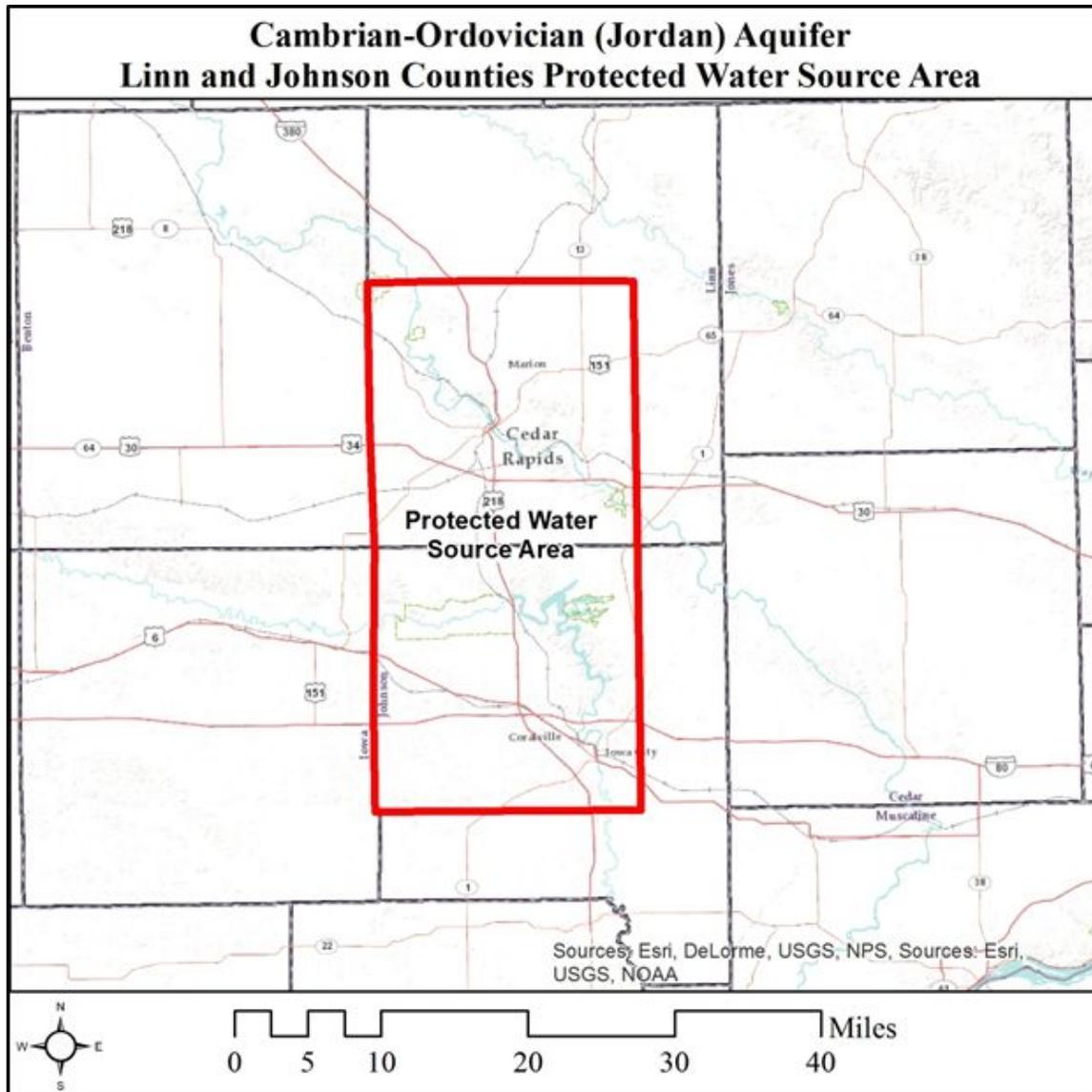
1. The entire following described area within Johnson County and within Linn County is defined as a protected water source.

Johnson County

- All areas of Township 79 North, Range 6 West.
- All areas of Township 79 North, Range 7 West.
- All areas of Township 79 North, Range 8 West.
- All areas of Township 80 North, Range 6 West.
- All areas of Township 80 North, Range 7 West.
- All areas of Township 80 North, Range 8 West.
- All areas of Township 81 North, Range 6 West.
- All areas of Township 81 North, Range 7 West.
- All areas of Township 81 North, Range 8 West.

Linn County

- All areas of Township 82 North, Range 6 West.
 - All areas of Township 82 North, Range 7 West.
 - All areas of Township 82 North, Range 8 West.
 - All areas of Township 83 North, Range 6 West.
 - All areas of Township 83 North, Range 7 West.
 - All areas of Township 83 North, Range 8 West.
 - All areas of Township 84 North, Range 6 West.
 - All areas of Township 84 North, Range 7 West.
 - All areas of Township 84 North, Range 8 West.
2. Map of the described protected water source area in Linn and Johnson Counties.



b. Reserved.

53.7(3) Cambrian-Ordovician (Jordan) aquifer in Webster County.

a. *Geographical area.* The protected water source area includes portions of Webster County. The actual geographical boundaries of the area are defined in subparagraph 53.7(3)“a”(3).

(1) New or modified water use permits. Any new application for a permit to withdraw groundwater or to increase an existing permitted withdrawal of groundwater from the Cambrian-Ordovician (Jordan) aquifer within the protected water source area will be restricted or denied if necessary to preserve public health and welfare.

(2) Withdrawal of groundwater. Withdrawal of groundwater from within the protected water source area may also be restricted or denied from water supply wells constructed in the Cambrian-Ordovician (Jordan) aquifer, public or private, and the construction of all new water supply wells in the Cambrian-Ordovician (Jordan) aquifer shall be restricted or denied, if necessary, to preserve public health and welfare or to minimize adverse effects to the “available” head (i.e., the original pressure head above the top of the aquifer). The Webster County health department is not authorized to issue a construction permit for a private well drilled into or through the Cambrian-Ordovician (Jordan) aquifer within the protected water source area without the approval of the department. The department’s

water supply engineering section will determine whether the proposed well can be constructed and may require that the well meet public water well standards.

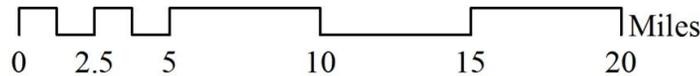
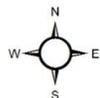
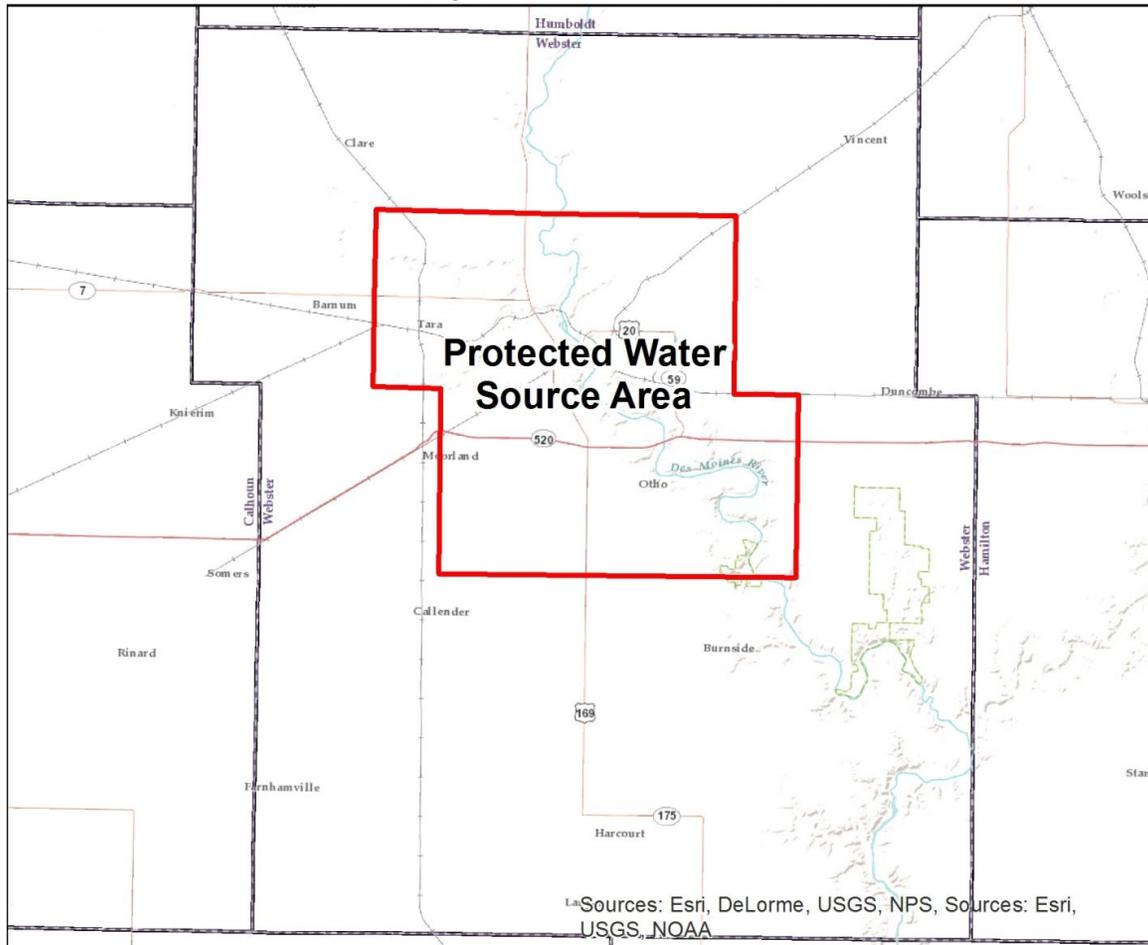
(3) Map of protected water source. The department shall maintain a map of the protected water source area.

1. The entire following described area within Webster County is defined as a protected water source.

- All areas of Township 88 North, Range 28 West.
- All areas of Township 88 North, Range 29 West.
- All areas of Township 89 North, Range 28 West.
- All areas of Township 89 North, Range 29 West.

2. Map of the described protected water source area in Webster County.

**Cambrian-Ordovician (Jordan) Aquifer
Webster County Protected Water Source Area**



b. Reserved.

NOTE: When protected sources are designated they will be listed as part of this rule.

This rule is intended to implement Iowa Code sections 455B.262, 455B.264 through 455B.274 and 455B.278.

[ARC 2053C, IAB 7/8/15, effective 8/12/15]

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[Filed ARC 2053C (Notice ARC 1914C, IAB 3/18/15), IAB 7/8/15, effective 8/12/15]

CHAPTER 64
WASTEWATER CONSTRUCTION AND OPERATION PERMITS

[Prior to 7/1/83, DEQ Ch 19]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—64.1(455B) Definitions. Rescinded IAB 3/11/09, effective 4/15/09.

567—64.2(455B) Permit to construct.

64.2(1) No person shall construct, install or modify any wastewater disposal system or part thereof or extension or addition thereto without, or contrary to any condition of, a construction permit issued by the director or by a local public works department authorized to issue such permits under 567—Chapter 9, nor shall any connection to a sewer extension in violation of any special limitation specified in a construction permit pursuant to 64.2(10) be allowed by any person subject to the conditions of the permit.

64.2(2) The site for each new wastewater treatment plant or expansion or upgrading of existing facilities must be inspected and approved by the department prior to submission of plans and specifications. Applications must be submitted in accordance with 567—60.4(455B).

64.2(3) Site approval under 64.2(2) shall be based on the criteria contained in the Ten States Standards, design manuals published by the department, applicable federal guidelines and standards, standard textbooks, current technical literature and applicable safety standards. To the extent that separation distances of this subrule conflict with the separation distances of Iowa Code section 455B.134(3) “f,” the greater distance shall prevail. The following separation distances from a treatment works shall apply unless a separation distance exception is provided in the “Iowa Wastewater Facilities Design Standards.” The separation distance from lagoons shall be measured from the water surface.

a. 1000 feet from the nearest inhabitable residence, commercial building, or other inhabitable structure. If the inhabitable or commercial building is the property of the owner of the proposed treatment facility, or there is written agreement with the owner of the building, the separation criteria shall not apply. Any such written agreement shall be filed with the county recorder and recorded for abstract of title purposes, and a copy submitted to the department.

b. 1000 feet from public shallow wells.

c. 400 feet from public deep wells.

d. 400 feet from private wells.

e. 400 feet from lakes and public impoundments.

f. 25 feet from property lines and rights-of-way.

When the above separation distances cannot be maintained for the expansion, upgrading or replacement of existing facilities, the separation distances shall be maintained at no less than 90 percent of the existing separation distance on the site, providing no data is available indicating that a problem has existed or will be created.

64.2(4) Applications for a construction permit must be submitted to the director in accordance with 567—60.4(455B) at least 120 days in advance of the date of start of construction.

64.2(5) The director shall act upon the application within 60 days of receipt of a complete application by either issuing a construction permit or denying the construction permit in writing unless a longer review period is required and the applicant is so notified in writing. Notwithstanding the 120-day requirement in 64.2(4), construction of the approved system may commence immediately after the issuance of a construction permit.

64.2(6) The construction permit shall expire if construction thereunder is not commenced within one year of the date of issuance thereof. The director may grant an extension of time to commence construction if it is necessary or justified, upon showing of such necessity or justification to the director.

64.2(7) The director may modify or revoke a construction permit for cause which shall include but not be limited to the following:

a. Failure to construct said wastewater disposal system or part thereof in accordance with the approved plans and specifications.

b. Violation of any term or condition of the permit.

c. Obtaining a permit by misrepresentation of facts or failure to disclose fully all material facts.

d. Any change during construction that requires material changes in the approved plans and specifications.

64.2(8) A construction permit shall not be required for the following:

- a.* Storm sewers or storm water disposal systems that transport only storm water.
- b.* Any new disposal system or extension or addition to any existing disposal system that receives only domestic or sanitary sewage from a building, housing or occupied by 15 persons or less.
- c.* A privately owned pretreatment facility, except an anaerobic lagoon, where a treatment unit or units provide partial reduction of the strength or toxicity of the waste stream prior to additional treatment and disposal by another person, corporation, or municipality. However, the department may require that the design basis and construction drawings be filed for information purposes.

64.2(9) Review of applications.

a. Review of applications for construction permits shall be based on the criteria contained in the “Iowa Wastewater Facilities Design Standards,” the Ten States Standards, applicable federal guidelines and standards, standard textbooks, current technical literature and applicable safety standards. To the extent of any conflict between the above criteria the “Iowa Wastewater Facilities Design Standards” standards shall prevail.

b. The chapters of the “Iowa Wastewater Facilities Design Standards”* that apply to wastewater facilities projects, and the date of adoption of those chapters are:

	<u>Chapter</u>	<u>Date of Adoption</u>
11.	Project submittals	April 25, 1979
12.	Iowa Standards for Sewer Systems	September 6, 1978 (Amended March 28, 1979 and May 20, 1987)
13.	Wastewater pumping stations and force mains	March 19, 1985
14.	Wastewater treatment works	March 22, 1984 (Amended May 20, 1987)
15.	Screening and grit removal	February 18, 1986
16.	Settling	March 22, 1984 (Amended May 20, 1987)
17.	Sludge handling & disposal	March 26, 1980
18.	Biological treatment	
	<i>A.</i> Fixed film media treatment	October 21, 1985
	<i>B.</i> Activated sludge	March 22, 1984
	<i>C.</i> Wastewater treatment ponds (Lagoons)	April 25, 1979 (Amended May 20, 1986 and May 20, 1987)
19.	Supplemental treatment processes	November 13, 1986
20.	Disinfection	February 18, 1986
21.	Land application of wastewater	April 25, 1979

*The design manual as adopted and amended is available upon request to department, also filed with administrative rules coordinator.

c. Variances from the design standards and siting criteria which provide in the judgment of the department for substantially equivalent or improved effectiveness may be requested when there are unique circumstances not found in most projects. The director may issue variances when circumstances are appropriate. The denial of a variance may be appealed to the commission.

d. When reviewing the variance request the director may consider the unique circumstances of the project, direct or indirect environmental impacts, the durability and reliability of the alternative, and the purpose and intent of the rule or standard in question.

e. Circumstances that would warrant consideration of a variance (which provides for substantially equivalent or improved effectiveness) may include the following:

(1) The utilization of new equipment or new process technology that is not explicitly covered by the current design standards.

(2) The application of established and acceptable technologies in an innovative manner not covered by current standards.

(3) It is reasonably clear that the conditions and circumstances which were considered in the adoption of the rule or standard are not applicable for the project in question and therefore the effective purpose of the rule will not be compromised if a variance is granted.

64.2(10) Applications for sanitary sewer extension construction permits shall conform to the Iowa Standards for Sewer Systems, and approval shall be subject to the following:

a. A sanitary sewer extension construction permit may be denied if, at the time of application, the treatment facility treating wastewater from the proposed sewer is not in substantial compliance with its operating permit or if the treatment facility receives wastes in volumes or quantities that exceed its design capacity and interfere with its operation or performance.

If the applicant is operating under a compliance schedule which is being adhered to that leads to resolution of the substantial compliance issues or if the applicant can demonstrate that the problem has been identified, the planning completed, and corrective measures initiated, then the construction permit may be granted.

b. A sanitary sewer extension construction permit may be denied if bypassing has occurred at the treatment facility, except when any of the following conditions are being met:

(1) The bypassing is due to a combined sewer system, and the facility is in compliance with a long-term CSO control plan approved by the department.

(2) The bypassing occurs as a result of a storm with an intensity or duration greater than that of a storm with a return period of five years. (See App. A)

(3) The department determines that timely actions are being taken to eliminate the bypassing.

c. A sanitary sewer extension construction permit may be denied if an existing downstream sewer is or will be overloaded or surcharged, resulting in bypassing, flooded basements, or overflowing manholes, unless:

(1) The bypassing or flooding is the result of a precipitation event with an intensity or duration greater than that of a storm with a return period of two years. (See App. A); or

(2) The system is under full-scale facility planning (I/I and SSES) and the applicant provides a schedule that is approved by the department for rehabilitating the system to the extent necessary to handle the additional loadings.

d. Potential loads. Construction permits may be granted for sanitary sewer extensions that are sized to serve future loads that would exceed the capacity of the existing treatment works. However, initial connections shall be limited to the load that can be handled by the existing treatment works. The department will determine this load and advise the applicant of the limit. This limitation will be in effect until additional treatment capacity has been constructed.

64.2(11) Certification of completion. Within 30 days after completion of construction, installation or modification of any wastewater disposal system or part thereof or extension or addition thereto, the permit holder shall submit a certification by a registered professional engineer that the project was completed in accordance with the approved plans and specifications.

[ARC 7625B, IAB 3/11/09, effective 4/15/09]

567—64.3(455B) Permit to operate.

64.3(1) Except as otherwise provided in this subrule, in 567—Chapter 65, and in 567—Chapter 69, no person shall operate any wastewater disposal system or part thereof without, or contrary to any condition of, an operation permit issued by the director. An operation permit is not required for the following:

a. A private sewage disposal system which does not discharge into, or have the potential to reach, a designated water of the state or subsurface drainage tile (NOTE: private sewage disposal systems under this exemption are regulated under 567—Chapter 69);

- b.* A semipublic sewage disposal system, the construction of which has been approved by the department and which does not discharge into a water of the state;
- c.* A pretreatment system, the effluent of which is to be discharged directly to another disposal system for final treatment and disposal;
- d.* A discharge from a geothermal heat pump which does not reach a navigable water.
- e.* Water well construction and well services related discharge that does not reach a water of the United States as defined in 40 CFR Part 122.2.
- f.* Discharges from the application of biological pesticides and chemical pesticides where the discharge does not reach a water of the United States as defined in 40 CFR Part 122.2.

64.3(2) Rescinded, effective 2/20/85.

64.3(3) The owner of any disposal system or part thereof in existence before August 21, 1973, for which a permit has been previously granted by the Iowa department of health or the Iowa department of environmental quality shall submit such information as the director may require to determine the conformity of such system and its operation with the rules of the department by no later than 60 days after the receipt of a request for such information from the director. If the director determines that the disposal system does not conform to the rules of the department, the director may require the owner to make such modifications as are necessary to achieve compliance. A construction permit shall be required, pursuant to 64.2(1), prior to any such modification of the disposal system.

64.3(4) Applications.

a. Individual permit. Except as provided in 64.3(4)“*b*,” applications for operation permits required under 64.3(1) shall be made on forms provided by the department, as noted in 567—subrule 60.3(2). The application for an operation permit under 64.3(1) shall be filed pursuant to 567—subrule 60.4(2). Permit applications for a new discharge of storm water associated with construction activity as defined in 567—Chapter 60 under “storm water discharge associated with industrial activity” must be submitted at least 60 days before the date on which construction is to commence. Upon completion of a tentative determination with regard to the permit application as described in 64.5(1)“*a*,” the director shall issue operation permits for applications filed pursuant to 64.3(1) within 90 days of the receipt of a complete application unless the application is for an NPDES permit or unless a longer period of time is required and the applicant is so notified.

b. General permit. A Notice of Intent for coverage under a general permit must be made on the appropriate form provided by the department listed in 567—subrule 60.3(2) and in accordance with 567—64.6(455B). A Notice of Intent must be submitted to the department according to the following:

(1) For existing storm water discharge associated with industrial activity, with the exception of discharges identified in subparagraphs (2) and (3) of this paragraph, on or before October 1, 1992.

(2) For any existing storm water discharge associated with industrial activity from a facility or construction site that is owned or operated by a municipality with a population of less than 100,000 other than an airport, power plant or uncontrolled sanitary landfill, on or before March 10, 2003.

For purposes of this subparagraph, municipality means city, town, borough, county, parish, district, association, or other public body created by or under state law. The entire population served by the public body shall be used in the determination of the population.

(3) For any existing storm water discharge associated with small construction activity on or before March 10, 2003.

(4) For storm water discharge associated with industrial activity which initiates operation after October 1, 1992, with the exception of discharges identified in subparagraphs (2) and (3) of this paragraph, where storm water discharge associated with industrial activity could occur as defined in rule 567—60.2(455B).

(5) For any private sewage disposal system installed after July 1, 1998, where subsoil discharge is not possible.

(6) For any discharge, except a storm water only discharge, from a mining or processing facility after July 18, 2001.

(7) For the discharge of biological pesticides and chemical pesticides which leave a residue to a water of the United States (as defined in 40 CFR Part 122.2) that meet any of the thresholds established in General Permit No. 7 after March 30, 2011.

64.3(5) Requirements for industries that discharge to another disposal system except storm water point sources.

a. The director may require any person discharging wastes to a publicly or privately owned disposal system to submit information similar to that required in an application for an operation permit, but no operation permit is required for such discharge.

Significant industrial users as defined in 567—Chapter 60 must submit a treatment agreement which meets the following criteria:

(1) The agreement must be on the treatment agreement form, number 542-3221, as provided by the department; and

(2) Must identify and limit the monthly average and the daily maximum quantity of compatible and incompatible pollutants discharged to the disposal system and the variations in daily flow; and

(3) Be signed and dated by the significant industrial user and the owner of the disposal system accepting the wastewater; and

(4) Provide that the quantities to be discharged to the disposal system must be in accordance with the applicable standards and requirements in 567—Chapter 62.

b. A significant industrial user must submit a new treatment agreement form 60 days in advance of a proposed expansion, production increase or process modification that may result in discharges of sewage, industrial waste, or other waste in excess of the discharge stated in the existing treatment agreement. An industry that would become a significant industrial user as a result of a proposed expansion, production increase or process modification shall submit a treatment agreement form 60 days in advance of the proposed expansion, production increase or process modification.

c. A treatment agreement form must be submitted at least 180 days before a new significant industrial user proposes to discharge into a wastewater disposal system. The owner of a wastewater disposal system shall notify the director by submitting a complete treatment agreement to be received at least 10 days prior to making any commitment to accept waste from a proposed new significant industrial user. However, the department may notify the owner that verification of the data in the treatment agreement may take longer than 10 days and advise that the owner should not enter into a commitment until the data is verified.

d. A treatment agreement form for each significant industrial user must be submitted with the facility plan or preliminary engineering report for the construction or modification of a wastewater disposal system. These agreements will be used in determining the design basis of the new or upgraded system.

e. Treatment agreement forms from significant industrial users shall be required as a part of the application for a permit to operate the wastewater disposal system receiving the wastes from the significant industrial user.

64.3(6) Rescinded, effective 7/23/86.

64.3(7) Operation permits may be granted for any period of time not to exceed five years. Applications for renewal of an operation permit must be submitted to the department 180 days in advance of the date the permit expires. General permits will be issued for a period not to exceed five years. Each permit to be renewed shall be subject to the provisions of all rules of the department in effect at the time of the renewal.

64.3(8) Identity of signatories of permit applications. The person who signs the application for a permit shall be:

a. Corporations. In the case of corporations, a responsible corporate officer. A responsible corporate officer means:

(1) A president, secretary, treasurer, or vice president in charge of a principal business function, or any other person who performs similar policy- or decision-making functions; or

(2) The manager of manufacturing, production, or operating facilities, if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

b. Partnerships. In the case of a partnership, a general partner.
c. Sole proprietorships. In the case of a sole proprietorship, the proprietor.
d. Municipal, state, federal, or other public agency. In the case of a municipal, state, or other public facility, either the principal executive officer or the ranking elected official. A principal executive officer of a public agency includes:

- (1) The chief executive officer of the agency; or
- (2) A senior executive officer having responsibility for the overall operations of a unit of the agency.

e. Storm water discharge associated with industrial activity from construction activities. In the case of a storm water discharge associated with construction activity, either the owner of the site or the general contractor.

f. Certification. Any person signing a document under paragraph “a” to “d” of this subrule shall make the following certification:

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for known violations.

The person who signs NPDES reports shall be a person described in this subrule, except that in the case of a corporation or a public body, monitoring reports required under the terms of the permit may be submitted by a duly authorized representative of the person described in this subrule. A person is a duly authorized representative if the authorization is made in writing by a person described in this subrule and the authorization specifies an individual or position having responsibility for the overall operation of the regulated facility, such as plant manager, superintendent, or position of equivalent responsibility, or an individual or position having overall responsibility for environmental matters for the corporation.

64.3(9) When necessary to comply with present standards which must be met at a future date, an operation permit shall include a schedule for the alteration of the permitted facility to meet said standards in accordance with 64.7(4) and 64.7(5). Such schedules shall not relieve the permittee of the duty to obtain a construction permit pursuant to 567—64.2(455B). When necessary to comply with a pretreatment standard or requirement which must be met at a future date, a significant industrial user will be given a compliance schedule for meeting those requirements.

64.3(10) Operation permits shall contain such conditions as are deemed necessary by the director to ensure compliance with all applicable rules of the department, including monitoring and reporting conditions, to protect the public health and beneficial uses of state waters, and to prevent water pollution from waste storage or disposal operations.

64.3(11) The director may amend, revoke and reissue, or terminate in whole or in part any individual operation permit or coverage under a general permit for cause. Except for general permits, the director may modify in whole or in part any individual operation permit for cause. A variance or modification to the terms and conditions of a general permit shall not be granted. If a variance or modification to a general permit is desired, the applicant must apply for an individual permit following the procedures in 64.3(4) “a.”

a. Permits may be amended, revoked and reissued, or terminated for cause either at the request of any interested person (including the permittee) or upon the director’s initiative. All requests shall be in writing and shall contain facts or reasons supporting the request.

b. Cause under this subrule includes the following:

- (1) Violation of any term or condition of the permit.
- (2) Obtaining a permit by misrepresentation of fact or failure to disclose fully all material facts.
- (3) A change in any condition that requires either a temporary or permanent reduction or elimination of the permitted discharge.

(4) Failure to submit such records and information as the director shall require both generally and as a condition of the permit in order to ensure compliance with the discharge conditions specified in the permit.

(5) Failure or refusal of an NPDES permittee to carry out the requirements of 64.7(7)“c.”

(6) Failure to provide all the required application materials or appropriate fees.

(7) A request for a modification of a schedule of compliance, an interim effluent limitation, or the minimum monitoring requirements pursuant to 567—paragraph 60.4(2)“b.”

(8) Causes listed in 40 CFR 122.62 and 122.64.

c. The permittee shall furnish to the director, within a reasonable time, any information that the director may request to determine whether cause exists for amending, revoking and reissuing, or terminating a permit, including a new permit application.

d. The filing of a request by an interested person for an amendment, revocation and reissuance, or termination does not stay any permit condition.

e. If the director decides the request is not justified, the director shall send the requester a brief written response giving a reason for the decision. Denials of requests for modification, revocation and reissuance, or termination are not subject to public notice, comment, hearings, or appeals.

f. Draft permits.

(1) If the director tentatively decides to amend, revoke and reissue, or terminate a permit, a draft permit shall be prepared according to 64.5(1).

(2) When a permit is amended under this paragraph, only those conditions to be modified shall be reopened when a new draft permit is prepared. All other aspects of the existing permit shall remain in effect for the duration of the permit.

(3) When a permit is revoked and reissued under this paragraph, the entire permit is reopened just as if the permit had expired and was being reissued.

(4) If the permit amendment falls under the definition of “minor amendment” in 567—60.2(455B), the permit may be amended without a draft permit or public notice.

(5) During any amendment, revocation and reissuance, or termination proceeding, the permittee shall comply with all conditions of the existing permit until a new final permit is reissued.

64.3(12) No permit may be issued:

a. When the applicant is required to obtain certification under Section 401 of the Clean Water Act and that certification has not been obtained or waived;

b. When the imposition of conditions cannot ensure compliance with the applicable water quality requirements of all affected states; or

c. To a new source or new discharger if the discharge from its construction or operation will cause or contribute to a violation of water quality standards. The owner or operator of a new source or new discharger proposing to discharge to a water segment which does not meet applicable water quality standards must demonstrate, before the close of the public comment period for a draft NPDES permit, that:

(1) There is sufficient remaining load in the water segment to allow for the discharge; and

(2) The existing dischargers to the segment are subject to compliance schedules designed to bring the segment into compliance with water quality standards.

The director may waive the demonstration if the director already has adequate information to demonstrate (1) and (2).

[ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 8520B, IAB 2/10/10, effective 3/17/10; ARC 9365B, IAB 2/9/11, effective 3/30/11; ARC 0529C, IAB 12/12/12, effective 1/16/13]

567—64.4(455B) Issuance of NPDES permits.

64.4(1) *Individual permit.* An individual NPDES permit is required when there is a discharge of a pollutant from any point source into navigable waters. An NPDES permit is not required for the following:

a. Reserved.

b. Discharges of dredged or fill material into navigable waters which are regulated under Section 404 of the Act;

c. The introduction of sewage, industrial wastes or other pollutants into a POTW by indirect dischargers. (This exclusion from requiring an NPDES permit applies only to the actual addition of materials into the subsequent treatment works. Plans or agreements to make such additions in the future do not relieve dischargers of the obligation to apply for and receive permits until the discharges of pollutants to navigable waters are actually eliminated. It also should be noted that, in all appropriate cases, indirect discharges shall comply with pretreatment standards promulgated by the administrator pursuant to Section 307(b) of the Act and adopted by reference by the commission);

d. Any discharge in compliance with the instruction of an On-Scene Coordinator pursuant to 40 CFR Part 300 (The National Oil and Hazardous Substances Pollution Contingency Plan) or 33 CFR 153.10(e) (Pollution by Oil and Hazardous Substances);

e. Any introduction of pollutants from non-point source agricultural and silvicultural activities, including storm water runoff from orchards, cultivated crops, pastures, range lands, and forest lands, except that this exclusion shall not apply to the following:

- (1) Discharges from concentrated animal feeding operations as defined in 40 CFR 122.23;
- (2) Discharges from concentrated aquatic animal production facilities as defined in 40 CFR 122.24;
- (3) Discharges to aquaculture projects as defined in 40 CFR 122.25;
- (4) Discharges from silvicultural point sources as defined in 40 CFR 122.27;

f. Return flows from irrigated agriculture; and

g. Water transfers, which are defined as activities that convey or connect navigable waters without subjecting the transferred water to intervening industrial, municipal, or commercial use.

64.4(2) General permit.

a. The director may issue general permits which are consistent with 64.4(2)“b” and the requirements specified in 567—64.6(455B), 567—64.7(455B), subrule 64.8(2), and 567—64.9(455B) for the following activities:

(1) Storm water point sources requiring an NPDES permit pursuant to Section 402(p) of the federal Clean Water Act and 40 CFR 122.26 (as amended through June 15, 1992).

(2) Private sewage disposal system discharges permitted under 567—Chapter 69 where subsoil discharge is not possible as determined by the administrative authority.

(3) Discharges from water well construction and related well services where the discharge will reach a water of the United States as defined in 40 CFR Part 122.2.

(4) For any discharge, except a storm water only discharge, from a mining or processing facility.

(5) Discharges from the application of biological pesticides and chemical pesticides which leave a residue where the discharge will reach a water of the United States as defined in 40 CFR Part 122.2.

b. Each general permit issued by the department must:

(1) Be adopted as an administrative rule in accordance with Iowa Code chapter 17A, the Administrative Procedure Act. Each proposed permit will be accompanied by a fact sheet setting forth the principal facts and methodologies considered during permit development,

(2) Correspond to existing geographic or political boundaries, and

(3) Be identified in 567—64.15(455B).

c. If an NPDES permit is required for an activity covered by a general permit, the applicant may seek either general permit coverage or an individual permit. Procedures and requirements for obtaining an individual NPDES permit are detailed in 64.3(4)“a.” Procedures for filing a Notice of Intent for coverage under a general permit are described in 567—64.6(455B) “Completing a Notice of Intent for Coverage Under a General Permit.”

64.4(3) Effect of a permit.

a. Except for any toxic effluent standards and prohibitions imposed under Section 307 of the Act and standards for sewage sludge use or disposal under Section 405(d) of the Act, compliance with a permit during its term constitutes compliance, for purposes of enforcement, with Sections 301, 302, 306, 307, 318, 403 and 405(a)-(b) of the Act, and equivalent limitations and standards set out in 567—Chapters 61 and 62. However, a permit may be terminated during its term for cause as set forth

in 64.3(11). Compliance with a permit condition which implements a particular standard for sewage sludge use or disposal shall be an affirmative defense in any enforcement action brought for a violation of that standard for sewage sludge use or disposal.

b. The issuance of a permit does not convey any property rights of any sort, or any exclusive privilege.

[ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 8520B, IAB 2/10/10, effective 3/17/10; ARC 9365B, IAB 2/9/11, effective 3/30/11]

567—64.5(455B) Notice and public participation in the individual NPDES permit process.

64.5(1) Formulation of tentative determination. The department shall make a tentative determination to issue or deny an operation or NPDES permit for the discharge described in a permit application in advance of the public notice as described in 64.5(2).

a. If the tentative determination is to issue an NPDES permit, the department shall prepare a permit rationale for each draft permit pursuant to 64.5(3) and a draft permit. The draft permit shall include the following:

(1) Effluent limitations identified pursuant to 64.6(2) and 64.6(3), for those pollutants proposed to be limited.

(2) If necessary, a proposed schedule of compliance, including interim dates and requirements, identified pursuant to 64.7(4) and 64.7(5), for meeting the effluent limitations and other permit requirements.

(3) Any other special conditions (other than those required in 64.6(5)) which will have a significant impact upon the discharge described in the permit application.

b. If the tentative determination is to deny an NPDES permit, the department shall prepare a notice of intent to deny the permit application. The notice of intent to deny an application will be placed on public notice as described in 64.5(2).

c. If the tentative determination is to issue an operation permit (non-NPDES permit), the department shall prepare a final permit and transmit the final permit to the applicant. The applicant will have 30 days to appeal the final operation permit.

d. If the tentative determination is to deny an operation permit (non-NPDES permit), no public notice is required. The department shall send written notice of the denial to the applicant. The applicant will have 30 days to appeal the denial.

64.5(2) Public notice for NPDES permits.

a. Prior to the issuance of an NPDES permit, a major NPDES permit amendment, or the denial of a permit application for an NPDES permit, public notice shall be circulated in a manner designed to inform interested and potentially interested persons of the proposed discharge and of the tentative determination to issue or deny an NPDES permit for the proposed discharge. Procedures for the circulation of public notice shall include at least the procedures of subparagraphs (1) to (3).

(1) The public notice for a draft NPDES permit or major permit amendment shall be circulated by the applicant within the geographical areas of the proposed discharge by posting the public notice in the post office and public places of the city nearest the premises of the applicant in which the effluent source is located; by posting the public notice near the entrance to the applicant's premises and in nearby places; and by publishing the public notice in local newspapers and periodicals, or, if appropriate, in a newspaper of general circulation. The public notice for the denial of a permit application shall be sent to the applicant and circulated by the department within the geographical areas of the proposed discharge by publishing the public notice in local newspapers and periodicals, or, if appropriate, in a newspaper of general circulation.

(2) The public notice shall be sent by the department to any person upon request.

(3) Upon request, the department shall add the name of any person or group to the distribution list to receive copies of all public notices concerning the tentative determinations with respect to the permit applications within the state or within a certain geographical area and shall send a copy of all public notices to such persons.

b. The department shall provide a period of not less than 30 days following the date of the public notice during which time interested persons may submit their written views on the tentative

determinations with respect to the permit application and request a public hearing pursuant to 64.5(6). Written comments may be submitted by paper or electronic means. All comments submitted during the 30-day comment period shall be retained by the department and considered by the director in the formulation of the director's final determinations with respect to the permit application. The period for comment may be extended at the discretion of the department. Pertinent and significant comments received during either the original comment period or an extended comment period shall be responded to in a responsiveness summary pursuant to 64.5(8).

c. The contents of the public notice of a draft NPDES permit, a major permit amendment, or the denial of a permit application for an NPDES permit shall include at least the following:

- (1) The name, address, and telephone number of the department.
- (2) The name and address of each applicant.
- (3) A brief description of each applicant's activities or operations which result in the discharge described in the permit application (e.g., municipal waste treatment plant, corn wet milling plant, or meat packing plant).

- (4) The name of the waterway to which each discharge of the applicant is made and a short description of the location of each discharge of the applicant on the waterway indicating whether such discharge is a new or an existing discharge.

- (5) A statement of the department's tentative determination to issue or deny an NPDES permit for the discharge or discharges described in the permit application.

- (6) A brief description of the procedures for the formulation of final determinations, including the 30-day comment period required by paragraph "b" of this subrule, procedures for requesting a public hearing and any other means by which interested persons may influence or comment upon those determinations.

- (7) The address, telephone number, and E-mail address of places at which interested persons may obtain further information, request a copy of the tentative determination and any associated documents prepared pursuant to 64.5(1), request a copy of the permit rationale described in 64.5(3), and inspect and copy permit forms and related documents.

d. No public notice is required for a minor permit amendment, including an amendment to correct typographical errors, include more frequent monitoring requirements, revise interim compliance schedule dates, change the owner name or address, include a local pretreatment program, or remove a point source outfall that does not result in the discharge of pollutants from other outfalls.

e. No public notice is required when a request for a permit amendment or a request for a termination of a permit is denied. The department shall send written notice of the denial to the requester and the permittee only. No public notice is required if an applicant withdraws a permit application.

64.5(3) *Permit rationales and notices of intent to deny.*

a. When the department has made a determination to issue an NPDES permit as described in 64.5(1), the department shall prepare and, upon request, shall send to any person a permit rationale with respect to the application described in the public notice. The contents of such permit rationales shall include at least the following information:

- (1) A detailed description of the location of the discharge described in the permit application.
- (2) A quantitative description of the discharge described in the permit application which includes:
 1. The average daily discharge in pounds per day of any pollutants which are subject to limitations or prohibitions under 64.7(2) or Section 301, 302, 306 or 307 of the Act and regulations published thereunder; and

2. For thermal discharges subject to limitation under the Act, the average and maximum summer and winter discharge temperatures in degrees Fahrenheit.

- (3) The tentative determinations required under 64.5(1).

- (4) A brief citation, including a brief identification of the uses for which the receiving waters have been classified, of the water quality standards applicable to the receiving waters and effluent standards and limitations applicable to the proposed discharge.

- (5) An explanation of the principal facts and the significant factual, legal, methodological, and policy questions considered in the preparation of the draft permit.

(6) Any calculations or other necessary explanation of the derivation of effluent limitations.

b. When the department has made a determination to deny an application for an NPDES permit as described in 64.5(1), the department shall prepare and, upon request, shall send to any person a notice of intent to deny with respect to the application described in the public notice. The contents of such notice of intent to deny shall include at least the following information:

(1) A detailed description of the location of the discharge described in the permit application; and

(2) A description of the reasons supporting the tentative decision to deny the permit application.

c. When the department has made a determination to issue an operation permit as described in 64.5(1), the department shall prepare a short description of the waste disposal system and the reasons supporting the decision to issue an operation permit. The description shall be sent to the operation permit applicant upon request.

d. When the department has made a determination to deny an application for an operation permit as described in 64.5(1), the department shall prepare and send written notice of the denial to the applicant only. The written denial shall include a description of the reasons supporting the decision to deny the permit application.

e. Upon request, the department shall add the name of any person or group to a distribution list to receive copies of permit rationales and notices of intent to deny and shall send a copy of all permit rationales and notices of intent to deny to such persons or groups.

64.5(4) Notice to other government agencies. Prior to the issuance of an NPDES permit, the department shall notify other appropriate government agencies of each complete application for an NPDES permit and shall provide such agencies an opportunity to submit their written views and recommendations. Notifications may be distributed and written views or recommendations may be submitted by paper or electronic means. Procedures for such notification shall include the procedures of paragraphs “a” to “f.”

a. At the time of issuance of public notice pursuant to 64.5(2), the department shall transmit the public notice to any other state whose waters may be affected by the issuance of the NPDES permit. Each affected state shall be afforded an opportunity to submit written recommendations to the department and to the regional administrator which the director may incorporate into the permit if issued. Should the director fail to incorporate any written recommendation thus received, the director shall provide to the affected state or states and to the regional administrator a written explanation of the reasons for failing to accept any written recommendation.

b. At the time of issuance of public notice pursuant to 64.5(2), the department shall send the public notice for proposed discharges (other than minor discharges) into navigable waters to the appropriate district engineer of the army corps of engineers.

(1) The department and the district engineer for each corps of engineers district within the state may arrange for: notice to the district engineer of minor discharges; waiver by the district engineer of the right to receive public notices with respect to classes, types, and sizes within any category of point sources and with respect to discharges to particular navigable waters or parts thereof; and any procedures for the transmission of forms, period of comment by the district engineer (e.g., 30 days), and for objections of the district engineer.

(2) A copy of any written agreement between the department and a district engineer shall be forwarded to the regional administrator and shall be available to the public for inspection and copying in accordance with 567—Chapter 2.

c. Upon request, the department shall send the public notice to any other federal, state, or local agency, or any affected county, and provide such agencies an opportunity to respond, comment, or request a public hearing pursuant to 64.5(6).

d. The department shall send the public notice for any proposed NPDES permit within the geographical area of a designated and approved management agency under Section 208 of the Act (33 U.S.C.1288).

e. The department shall send the public notice to the local board of health for the purpose of assisting the applicant in coordinating the applicable requirements of the Act and Iowa Code chapter 455B with any applicable requirements of the local board of health.

f. Upon request, the department shall provide any of the entities listed in 64.5(4) “a” through “e” with a copy of the permit rationale, permit application, or proposed permit prepared pursuant to 64.5(1).

64.5(5) Public access to NPDES information. The records of the department connected with NPDES permits are available for public inspection and copying to the extent provided in 567—Chapter 2.

64.5(6) Public hearings on proposed NPDES permits. The applicant, any affected state, the regional administrator, or any interested agency, person or group of persons may request or petition for a public hearing with respect to an NPDES application. Any such request shall clearly state issues and topics to be addressed at the hearing. Any such request or petition for public hearing must be filed with the director within the 30-day period prescribed in 64.5(2) “b” and shall indicate the interest of the party filing such request and the reasons why a hearing is warranted. The director shall hold an informal and noncontested case hearing if there is a significant public interest (including the filing of requests or petitions for such hearing) in holding such a hearing. Frivolous or insubstantial requests for hearing may be denied by the director. Instances of doubt should be resolved in favor of holding the hearing. Any hearing held pursuant to this subrule shall be held in the geographical area of the proposed discharge, or other appropriate area in the discretion of the director, and may, as appropriate, consider related groups of permit applications.

64.5(7) Public notice of public hearings on proposed NPDES permits.

a. Public notice of any hearing held pursuant to 64.5(6) shall be circulated at least as widely as was the notice of the tentative determinations with respect to the permit application.

(1) Notice shall be published in at least one newspaper of general circulation within the geographical area of the discharge;

(2) Notice shall be sent to all persons and government agencies which received a copy of the notice for the permit application;

(3) Notice shall be mailed to any person or group upon request; and

(4) Notice pursuant to subparagraphs (1) and (2) of this paragraph shall be made at least 30 days in advance of the hearing.

b. The contents of public notice of any hearing held pursuant to 64.5(6) shall include at least the following:

(1) The name, address, and telephone number of the department;

(2) The name and address of each applicant whose application will be considered at the hearing;

(3) The name of the water body to which each discharge is made and a short description of the location of each discharge to the water body;

(4) A brief reference to the public notice issued for each NPDES application, including the date of issuance;

(5) Information regarding the time and location for the hearing;

(6) The purpose of the hearing;

(7) A concise statement of the issues raised by the person or persons requesting the hearing;

(8) The address and telephone number of the premises where interested persons may obtain further information, request a copy of the draft NPDES permit prepared pursuant to 64.5(1), request a copy of the permit rationale prepared pursuant to 64.5(3), and inspect and copy permit forms and related documents;

(9) A brief description of the nature of the hearing, including the rules and procedures to be followed; and

(10) The final date for submission of comments (paper or electronic) regarding the tentative determinations with respect to the permit application.

64.5(8) Response to comments. At the time a final NPDES permit is issued, the director shall issue a response to significant and pertinent comments in the form of a responsiveness summary. A copy of the responsiveness summary shall be sent to the permit applicant, and the document shall be made available to the public upon request. The responsiveness summary shall:

a. Specify which provisions, if any, of the draft permit have been changed in the final permit decision and the reasons for the changes; and

b. Briefly describe and respond to all significant and pertinent comments on the draft permit raised during the public comment period provided for in the public notice or during any hearing. Comments on a draft permit may be submitted by paper or electronic means or orally at a public hearing. [ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 0529C, IAB 12/12/12, effective 1/16/13]

567—64.6(455B) Completing a Notice of Intent for coverage under a general permit.

64.6(1) Contents of a complete Notice of Intent. An applicant proposing to conduct activities covered by a general permit shall file a complete Notice of Intent by submitting to the department materials required in paragraphs “a” to “c” of this subrule except that a Notice of Intent is not required for discharges authorized under General Permit No. 6.

a. Notice of Intent Application Form. The following Notice of Intent forms must be completed in full.

(1) General Permit No. 1 “Storm Water Discharge Associated with Industrial Activity,” Form 542-1415.

(2) General Permit No. 2 “Storm Water Discharge Associated with Industrial Activity for Construction Activities,” Form 542-1415.

(3) General Permit No. 3 “Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, Rock Crushing Plants and Construction Sand and Gravel Facilities,” Form 542-1415.

(4) General Permit No. 4 “Discharge from On-Site Wastewater Treatment and Disposal Systems,” Form 542-1541.

(5) General Permit No. 5 “Discharge from Mining and Processing Facilities,” Form 542-4006.

(6) General Permit No. 7, “Pesticide General Permit (PGP) for Point Source Discharges to Waters of the United States From the Application of Pesticides.”

b. General permit fee. The general permit fee according to the schedule in 567—64.16(455B) payable to the Department of Natural Resources.

c. Public notification. The following public notification requirements must be completed for the corresponding general permit.

(1) General Permits No. 1, No. 2 and No. 3. A demonstration that a public notice was published in at least one newspaper with the largest circulation in the area in which the facility is located or the activity will occur. The newspaper notice shall, at the minimum, contain the following information:

PUBLIC NOTICE OF STORM WATER DISCHARGE

The (applicant name) plans to submit a Notice of Intent to the Iowa Department of Natural Resources to be covered under NPDES General Permit (select the appropriate general permit—No. 1 “Storm Water Discharge Associated with Industrial Activity” or General Permit No. 2 “Storm Water Discharge Associated with Industrial Activity for Construction Activities”). The storm water discharge will be from (description of industrial activity) located in (¼ section, township, range, county). Storm water will be discharged from (number) point source(s) and will be discharged to the following streams: (stream name(s)).

Comments may be submitted to the Storm Water Discharge Coordinator, IOWA DEPARTMENT OF NATURAL RESOURCES, Environmental Protection Division, 900 E. Grand Avenue, Des Moines, IA 50319-0034. The public may review the Notice of Intent from 8 a.m. to 4:30 p.m., Monday through Friday, at the above address after it has been received by the department.

(2) General Permits No. 4, No. 5, No. 6, and No. 7. There are no public notification requirements for these permits.

64.6(2) Authorization to discharge under a general permit. Upon the submittal of a complete Notice of Intent in accordance with 64.6(1) and 64.3(4)“b,” the applicant is authorized to discharge after evaluation of the Notice of Intent by the department is complete and the determination has been made that the contents of the Notice of Intent satisfy the requirements of 567—Chapter 64. The

discharge authorization date for all storm water discharges associated with industrial activity that are in existence on or before October 1, 1992, shall be October 1, 1992. The applicant will receive notification by the department of coverage under the general permit. If any of the items required for filing a Notice of Intent specified in 64.6(1) are missing, the department will consider the application incomplete and will notify the applicant of the incomplete items.

64.6(3) *General permit suspension or revocation.* In addition to the causes for suspension or revocation which are listed in 64.3(11), the director may suspend or revoke coverage under a general permit issued to a facility or a class of facilities for the following reasons and require the applicant to apply for an individual NPDES permit in accordance with 64.3(4) “a”:

a. The discharge would not comply with Iowa’s water quality standards pursuant to 567—Chapter 61, or

b. The department finds that the activities associated with a Notice of Intent filed with the department do not meet the conditions of the general permit. The department will notify the affected discharger and establish a deadline, not longer than one year, for submitting an individual permit application, or

c. The department finds that water well construction and well service discharge are not managed in a manner consistent with the conditions specified in General Permit No. 6, or

d. The department finds that discharges from biological pesticides and chemical pesticides which leave a residue are not managed in a manner consistent with the conditions specified in General Permit No. 7.

64.6(4) *Eligibility for individual permit holders.* A person holding an individual NPDES permit for an activity covered by a general permit may apply for coverage under a general permit upon expiration of the individual permit and by filing a Notice of Intent according to procedures described in 64.3(4) “b.”

64.6(5) *Filing a Notice of Discontinuation.* A notice to discontinue the activity covered by the NPDES general permit shall be made in writing to the department 30 days prior to or after discontinuance of the discharge. For storm water discharge associated with industrial activity for construction activities, the discharge will be considered as discontinued when “final stabilization” has been reached. Final stabilization means that all soil-disturbing activities at the site have been completed and that a uniform perennial vegetative cover with a density of 70 percent for the area has been established or equivalent stabilization measures have been employed.

The notice of discontinuation shall contain the following:

a. The name of the facility to which the permit was issued,

b. The general permit number and permit authorization number,

c. The date the permitted activity was, or will be, discontinued, and

d. A signed certification in accordance with the requirements in the general permit.

64.6(6) *Transfer of ownership—construction activity part of a larger common plan of development.* For construction activity which is part of a larger common plan of development, such as a housing or commercial development project, in the event a permittee transfers ownership of all or any part of property subject to NPDES General Permit No. 2, both the permittee and transferee shall be responsible for compliance with the provisions of the general permit for that portion of the project which has been transferred, including when the transferred property is less than one acre in area, provided that:

a. The transferee is notified in writing of the existence and location of the general permit and pollution prevention plan, and of the transferee’s duty to comply, and proof of such notice is included with the notice to the department of the transfer.

b. If the transferee agrees, in writing, to become the sole responsible permittee for the property which has been transferred, then the transferee shall be solely responsible for compliance with the provisions of the general permit for the transferred property.

c. If the transferee agrees, in writing, to obtain coverage under NPDES General Permit No. 2 for the property which has been transferred, then the transferee is required to obtain coverage under NPDES General Permit No. 2 for the transferred property. After the transferee has agreed, in writing, to obtain coverage under NPDES General Permit No. 2 for the transferred property, the authorization issued under NPDES General Permit No. 2 to the transferor for the transferred property shall be considered by the

department as not providing NPDES permit coverage for the transferred property and the transferor's authorization issued under NPDES General Permit No. 2 for, and only for, the transferred property shall be deemed by the department as being discontinued without further action of the transferor.

d. All notices as described in this subrule shall contain the name of the development as submitted to the department in the original Notice of Intent and as modified by any subsequent written notices of name changes submitted to the department, the authorization number assigned to the authorization by the department, the legal description of the transferred property including lot number, if any, and any other information necessary to precisely locate the transferred property and to establish the legality of the document.

[ARC 8520B, IAB 2/10/10, effective 3/17/10; ARC 9365B, IAB 2/9/11, effective 3/30/11; ARC 1337C, IAB 2/19/14, effective 3/26/14]

567—64.7(455B) Terms and conditions of NPDES permits.

64.7(1) Prohibited discharges. No NPDES permit may authorize any of the discharges prohibited by 567—62.1(455B).

64.7(2) Application of effluent, pretreatment and water quality standards and other requirements. Each NPDES permit shall include any of the following that is applicable:

a. An effluent limitation guideline promulgated by the administrator under Sections 301 and 304 of the Act and adopted by reference by the commission in 567—62.4(455B).

b. A standard of performance for a new source promulgated by the administrator under Section 306 of the Act and adopted by reference by the commission in 567—62.4(455B).

c. An effluent standard, effluent prohibition or pretreatment standard promulgated by the administrator under Section 307 of the Act and adopted by reference by the commission in 567—62.4(455B) or 567—62.5(455B).

d. A water quality related effluent limitation established by the administrator pursuant to Section 302 of the Act.

e. Prior to promulgation by the administrator of applicable effluent and pretreatment standards under Sections 301, 302, 306, and 307 of the Act, such conditions as the director determines are necessary to carry out the provisions of the Act.

f. Any other limitation, including those:

(1) Necessary to meet water quality standards, treatment or pretreatment standards, or schedules of compliance established pursuant to any Iowa law or regulation, or to implement the antidegradation policy in 567—subrule 61.2(2); or

(2) Necessary to meet any other federal law or regulation; or

(3) Required to implement any applicable water quality standards; or

(4) Any legally applicable requirement necessary to implement total maximum daily loads established pursuant to Section 303(d) of the Act and incorporated in the continuing planning process approved under Section 303(e) of the Act and any regulations and guidelines issued pursuant thereto.

g. Limitations must control all pollutants or pollutant parameters which the director determines are or may be discharged at a level which will cause, have the reasonable potential to cause, or contribute to an excursion above any water quality standard, including narrative criteria, in 567—Chapter 61. When the permitting authority determines that a discharge causes, has the reasonable potential to cause, or contributes to an in-stream excursion of the water quality standard for an individual pollutant, the permit must contain effluent limits for that pollutant.

h. Any more stringent legally applicable requirements necessary to comply with a plan approved pursuant to Section 208(b) of the Act.

In any case where an NPDES permit applies to effluent standards and limitations described in paragraph “a,” “b,” “c,” “d,” “e,” “f,” “g,” or “h,” the director must state that the discharge authorized by the permit will not violate applicable water quality standards and must have prepared some verification of that statement. In any case where an NPDES permit applies any more stringent effluent limitation, described in 64.7(2)“f”(1) or “g,” based upon applicable water quality standards,

a waste load allocation must be prepared to ensure that the discharge authorized by the permit is consistent with applicable water quality standards.

64.7(3) Effluent limitations in issued NPDES permits. In the application of effluent standards, and limitations, water quality standards, and other legally applicable requirements, pursuant to 64.7(2), the director shall, for each issued NPDES permit, specify average and maximum daily quantitative limitations for the level of pollutants in the authorized discharge in terms of weight (except pH, temperature, radiation, and any other pollutants not appropriately expressed by weight). The director may, in addition to the specification of daily quantitative limitations by weight, specify other limitations such as average or maximum concentration limits, for the level of pollutants authorized in the discharge.

[COMMENT. The manner in which effluent limitations are expressed will depend upon the nature of the discharge. Continuous discharges shall be limited by daily loading figures and, where appropriate, may be limited as to concentration or discharge rate (e.g., for toxic or highly variable continuous discharges). Batch discharges should be more particularly described and limited in terms of (i) frequency (e.g., to occur not more than once every three weeks), (ii) total weight (e.g., not to exceed 300 pounds per batch discharge), (iii) maximum rate of discharge of pollutants during the batch discharge (e.g., not to exceed 2 pounds per minute), and (iv) prohibition or limitation by weight, concentration, or other appropriate measure of specified pollutants (e.g., shall not contain at any time more than 0.1 ppm zinc or more than ¼ pound of zinc in any batch discharge). Other intermittent discharges, such as recirculation blowdown, should be particularly limited to comply with any applicable water quality standards and effluent standards and limitations.]

64.7(4) Schedules of compliance in issued NPDES permits. The director shall follow the following procedure in setting schedules in NPDES permit conditions to achieve compliance with applicable effluent standards and limitations, water quality standards, and other legally applicable requirements.

a. With respect to any discharge which is not in compliance with applicable effluent standards and limitations, applicable water quality standards, or other legally applicable requirements listed in 64.7(2) “f” and 64.7(2) “g,” the permittee shall be required to take specific steps to achieve compliance with: applicable effluent standards and limitations; if more stringent, water quality standards; or if more stringent, legally applicable requirements listed in 64.7(2) “f” and 64.7(2) “g.” In the absence of any legally applicable schedule of compliance, such steps shall be achieved in the shortest, reasonable period of time, such period to be consistent with the guidelines and requirements of the Act.

b. In any case where the period of time for compliance specified in paragraph 64.7(4) “a” exceeds one year, a schedule of compliance shall be specified in the permit which shall set forth interim requirements and the dates for their achievement; in no event shall more than one year elapse between interim dates. If the time necessary for completion of the interim requirements (such as the construction of a treatment facility) is more than one year and is not readily divided into stages for completion, interim dates shall be specified for the submission of reports of progress toward completion of the interim requirement.

[COMMENT. Certain interim requirements such as the submission of preliminary or final plans often require less than one year, and thus a shorter interval should be specified. Other requirements such as the construction of treatment facilities may require several years for completion and may not readily subdivide into one-year intervals. Long-term interim requirements should nonetheless be subdivided into intervals not longer than one year at which the permittee is required to report progress to the director pursuant to 64.7(4) “c.”]

c. Either before or up to 14 days following each interim date and the final date of compliance the permittee shall provide the department with written notice of the permittee’s compliance or noncompliance with the interim or final requirement.

d. On the last day of the months of February, May, August, and November the director shall transmit to the regional administrator a list of all instances, as of 30 days prior to the date of such report, of failure or refusal of a permittee to comply with an interim or final requirement or to notify the department of compliance or noncompliance with each interim or final requirement (as required pursuant to paragraph “b” of this subrule). Such list shall be available to the public for inspection and copying and shall contain at least the following information with respect to each instance of noncompliance:

- (1) Name and address of each noncomplying permittee.
- (2) A short description of each instance of noncompliance (e.g., failure to submit preliminary plans, two-week delay in commencement of construction of treatment facility; failure to notify of compliance with interim requirement to complete construction by June 30).
- (3) A short description of any actions or proposed actions by the permittee to comply or by the director to enforce compliance with the interim or final requirement.
- (4) Any details which tend to explain or mitigate an instance of noncompliance with an interim or final requirement (e.g., construction delayed due to materials shortage, plan approval delayed by objections).

e. If a permittee fails or refuses to comply with an interim or final requirement in an NPDES permit such noncompliance shall constitute a violation of the permit for which the director may, pursuant to 567—Chapters 7 and 60, modify, suspend or revoke the permit or take direct enforcement action.

64.7(5) *Schedules of compliance in issued NPDES permits for disadvantaged communities.* If compliance with federal regulations, applicable requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department will result in substantial and widespread economic and social impact (SWESI) to the ratepayers and the affected community, the director may establish in an NPDES permit a schedule of compliance that will result in an improvement of water quality and reasonable progress toward complying with the applicable requirements but does not result in SWESI. Schedules of compliance established under this subrule are intended to result in compliance with the applicable federal and state regulations and requirements by the regulated entity and the affected community.

a. Disadvantaged community status. The director shall find that a regulated entity and the affected community are a disadvantaged community by evaluating all of the following:

- (1) The ability of the regulated entity and the affected community to pay for a project based on the ratio of the total annual project costs per household to median household income (MHI),
- (2) MHI in the community and the unemployment rate of the county in which the community is located, and
- (3) The outstanding debt of the system and the bond rating of the community.

b. Disadvantaged community analysis (DCA). A regulated entity or affected community must submit a disadvantaged community analysis (DCA) to the director to be considered for disadvantaged status. A DCA may only be submitted when new requirements in a proposed or reissued NPDES permit may result in SWESI.

- (1) A DCA may be submitted by any of the following:

1. A wastewater disposal system owned by a municipal corporation or other public body created by or under Iowa law and having jurisdiction over disposal of sewage, industrial wastes or other wastes, or a designated and approved management agency under Section 208 of the Act (a POTW);

2. A wastewater disposal system for the treatment or disposal of domestic sewage which is not a private sewage disposal system and which is not owned by a city, a sanitary sewer district, or a designated and approved management agency under Section 208 of the Act (33 U.S.C. 1288) (a semipublic system); or

3. Any other owner of a wastewater disposal system that is not a private sewage disposal system and does not discharge industrial wastes. “Private sewage disposal system” and “industrial waste” are defined in rule 567—60.2(455B).

- (2) A DCA may be submitted prior to the issuance of an initial NPDES permit if the facility does not discharge industrial wastes and is not a new source or new discharger. “New source” is defined in rule 567—60.2(455B). “New discharger” means any building, structure, facility, or installation from which there is or may be a discharge of pollutants; that did not commence the discharge of pollutants at a particular site prior to August 13, 1979; that is not a new source; and that has never received a finally effective NPDES permit for discharges at that site.

- (3) A DCA may be submitted by the entities noted in subparagraph 64.7(5)“b”(1) above for consideration of a disadvantaged community loan interest rate under the clean water state revolving fund.

c. Contents of a DCA.

- (1) A DCA must contain all of the following:
1. Proposed total annual project costs as defined in paragraph 64.7(5) “d”;
 2. The number of households in the affected community or, if the entity is not serving households, the number of ratepayers;
 3. A description of the bond rating of the affected community over the last year, if available;
 4. The user rates, as follows:
 - If the DCA is submitted by or for a municipality or other community, the current sewer rate ordinances, including the sewer rates of any industrial users;
 - If the DCA is submitted by or for a water treatment facility, the water rate schedules or tables;
 - or
 - If the DCA is submitted by or for an entity other than a municipality, community, or water treatment facility, the monthly ratepayer charge for wastewater treatment;
 5. An explanation of why the regulated entity or affected community believes that compliance with the proposed requirements will result in SWESI.

(2) If the DCA is submitted by or for an entity other than a municipality, community, or water treatment facility, the DCA must also contain either:

1. For entities with more than ten households or ratepayers, the median household or ratepayer income, as determined by an income survey conducted by the regulated entity based on the Iowa community development block grant income survey guidelines (the survey must be included in the DCA); or
2. For entities with ten or fewer households or ratepayers, an estimate of median household or ratepayer income.

d. Definition of total annual project costs. “Total annual project costs” means the current costs of wastewater treatment in the community (if any) plus the future costs of proposed wastewater system improvements that will meet or exceed all applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or requirements of an order of the department. Total annual project costs shall include any current and proposed facility operation and maintenance costs and any existing (outstanding) and proposed system debt, as expressed in current and proposed sewer rates. The costs of the proposed wastewater treatment shall assume a 30-year loan period at an interest rate equal to the current state revolving fund interest rate. Awarded grant funding must be subtracted from the total annual project costs.

The formula for the calculation of total annual project costs for a regulated entity and affected community is: total annual project costs = [(Estimated costs to design and build proposed project - Awarded grant funding) amortized over 30 years] + Current annual system budget (if any), including operation and maintenance (O&M) and existing debt service + Future annual O&M costs.

e. Disadvantaged community matrix (DCM). The department hereby incorporates by reference “Disadvantaged Community Matrix,” DNR Form 542-1246, effective January 16, 2013. This document may be obtained on the department’s NPDES Web site.

Upon receipt of a complete DCA, the director shall use the disadvantaged community matrix (DCM) to evaluate the disadvantaged status of the community. Compliance with the applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department shall be considered to result in SWESI, and the regulated entity and affected community shall be considered a disadvantaged community, if the point total derived from the DCM is equal to or greater than 12. The following data sources shall be used to derive the point total in the DCM:

- (1) The total annual project costs as stated in the DCA;
- (2) The number of households or ratepayers in a community as stated in the DCA;
- (3) The bond rating of the community, if available, as stated in the DCA;
- (4) The MHI of either:
 1. The community, as found in the most recent American Community Survey or United States Census or as stated in an income survey that is conducted by the regulated entity or community and is based on the Iowa community development block grant income survey guidelines; or

2. The ratepayer group, as stated in an income survey that is conducted by the regulated entity and is based on the Iowa community development block grant income survey guidelines; and

(5) The unemployment rate of the county where the community is located and of the state as found in the most recent Iowa Workforce Information Network unemployment data.

The ratio of the total annual project costs per household or per ratepayer to MHI shall be calculated in the DCM as follows: The total annual project costs shall be divided by the number of households or ratepayers to obtain the costs per household or per ratepayer, and the costs per household or per ratepayer shall be divided by the MHI to obtain the ratio.

f. Ratio. The director shall not consider a regulated entity or affected community a disadvantaged community if the ratio of compliance costs to MHI is less than 1 percent. The director shall consider a regulated entity or affected community a disadvantaged community if the ratio of compliance costs to MHI is greater than or equal to 2 percent. If the ratio of compliance costs to MHI is greater than or equal to 1 percent and less than 2 percent, the director shall use the DCM to determine if the community is disadvantaged. The ratio of compliance costs to MHI shall be the ratio of the total annual project costs per household to MHI as calculated in the DCM.

g. Compliance schedule for a disadvantaged community. A schedule of compliance established in an NPDES permit for a disadvantaged community as a result of SWESI may contain one or two parts as necessary to comply with the applicable federal regulations and requirements in 567—Chapters 60, 61, 62, 63, and 64.

(1) The first part of a schedule of compliance for a disadvantaged community shall encompass one five-year NPDES permit cycle and shall require the permit holder to submit an alternatives report, an alternatives implementation compliance plan (AICP), and annual reports of progress that contain brief updates regarding the completion of the alternatives report and the AICP.

1. Alternatives report. The alternatives report must detail the alternative pollution control measures that will be investigated and contain an examination of all other appropriate measures that may achieve compliance with applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department without creating SWESI. The alternatives report must describe which measures will be evaluated for feasibility and affordability during the next portion of the compliance schedule. Alternative pollution control measures may include, but are not limited to, facility upgrades, construction of a new facility, relocation of the discharge point(s), regionalization, or outfall consolidation. Other appropriate measures may include, but are not limited to, mixing zone studies, consideration of seasonal limitations or site-specific data, alteration of current facility operations, intermittent discharges, source reduction, effluent recycling or reuse, or renegotiation of treatment agreements. The alternatives report must also include a plan for pursuing funding options, including grants and low-interest loans. The alternatives report shall be submitted no later than two years after permit issuance.

2. Alternatives implementation compliance plan (AICP). The AICP shall include the results of the investigation detailed in the alternatives report, a description of any feasible and affordable alternative(s) that will be implemented, a schedule of the time necessary to implement the alternative(s), and an updated DCA. The AICP shall be submitted no later than 4½ years after permit issuance.

(2) If the entity or community continues to qualify as disadvantaged according to the DCM evaluation based on the DCA submitted with the AICP, the entity or community may receive a second schedule of compliance as specified in this subrule. The second schedule of compliance for a disadvantaged community may contain either the implementation schedule from the AICP or a schedule for submittal of a future compliance plan (FCP).

1. AICP implementation schedule. If the AICP proposes a schedule for implementation of one or more feasible alternatives, the proposed schedule shall be included in the reissued NPDES permit for the disadvantaged community.

2. Future compliance plan (FCP). The submittal of an FCP will be necessary only if the AICP concludes that the disadvantaged community cannot feasibly implement any alternatives and if the community is still disadvantaged according to the updated information in the DCA submitted with the AICP. The FCP shall detail how the disadvantaged community will meet the applicable federal

regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department and the period necessary to do so. An FCP shall review the types of technology capable of treating the pollutant of concern, as well as the costs of installing and operating each type of technology. All technically feasible alternatives shall be explored. The FCP shall be submitted no later than three years after permit issuance. A schedule of compliance requiring the submittal of an FCP shall also require the submittal of annual reports of progress that contain updated financial information, an updated DCA, and a brief update regarding the completion or implementation of the FCP. If the DCM evaluation determines that an entity or community is no longer disadvantaged based on the most recent DCA, the NPDES permit may be amended to change the schedule of compliance.

3. Schedule extension. The second part of a schedule of compliance for a disadvantaged community may be extended at the discretion of the director.

(3) Schedules of compliance issued in accordance with this subrule shall comply with paragraphs 64.7(4)“b” through “e.”

64.7(6) *Disadvantaged unsewered communities.* If compliance with applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department will result in substantial and widespread economic and social impact (SWESI) to the ratepayers of an unsewered community, the director may negotiate a compliance agreement that will result in an improvement of water quality and reasonable progress toward complying with the applicable requirements but does not result in SWESI.

a. Disadvantaged unsewered community status. The director shall find that an unsewered community is a disadvantaged unsewered community by evaluating all of the following:

- (1) The ability of the unsewered community to pay for a project based on the ratio of the total annual project costs per household to MHI,
- (2) The unemployment rate in the county where the unsewered community is located, and
- (3) The MHI of the unsewered community.

b. Disadvantaged unsewered community analysis (DUCA). To be considered for disadvantaged unsewered community status, an unsewered community may submit a disadvantaged unsewered community analysis (DUCA) to the director prior to the issuance of or amendment to an administrative order with requirements that could result in SWESI and that are based on applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department. Only unsewered communities may submit a DUCA under this subrule. For the purposes of this subrule, an unsewered community is defined as a grouping of ten or more residential houses with a density of one house or more per acre and with either no wastewater treatment or inadequate wastewater treatment. An entity defined in rule 567—60.2(455B) as a private sewage disposal system may not submit a DUCA or qualify for a disadvantaged unsewered community compliance agreement under paragraph 64.7(6)“g.” A DUCA may also be submitted for consideration of a disadvantaged community loan interest rate under the clean water state revolving fund.

c. Contents of a DUCA. A DUCA must contain:

- (1) Proposed total annual project costs as defined in paragraph 64.7(6)“d”;
- (2) The number of households in the unsewered community and source of household information;
- (3) Total amount of any awarded grant funding;
- (4) An explanation of why the unsewered community believes that compliance with the proposed requirements will result in SWESI.

If no MHI information is available for the unsewered community, the community should conduct a rate survey to determine the MHI. The survey must be conducted in accordance with the Iowa community development block grant income survey guidelines. In addition, the survey must be attached to the DCA.

d. Definition of total annual project costs. “Total annual project costs” means the future costs of proposed wastewater system installation or improvements that will meet or exceed all applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or requirements of an order of the department. Total annual project costs shall include the proposed facility operation and maintenance (O&M) costs and the proposed debt of the system as expressed in the proposed sewer rates. The costs of the proposed wastewater treatment shall assume a 30-year loan period at an interest rate equal to the

current state revolving fund interest rate. Awarded grant funding must be subtracted from the total annual project costs.

The formula for the calculation of total annual project costs for an unsewered community is: total annual project costs = [(Estimated costs to design and build proposed project - Awarded grant funding) amortized over 30 years] + Future annual O&M costs.

e. Disadvantaged unsewered community matrix (DUCM). The department hereby incorporates by reference “Disadvantaged Unsewered Community Matrix,” DNR Form 542-1247, effective January 16, 2013. This document may be obtained on the department’s NPDES Web site.

Upon receipt of a complete DUCA, the director shall use the disadvantaged unsewered community matrix (DUCM) to evaluate the disadvantaged status of the unsewered community. Compliance with applicable federal regulations, requirements in 567—Chapters 60, 61, 62, 63, and 64, or an order of the department shall be considered to result in SWESI, and the unsewered community shall be considered a disadvantaged unsewered community, if the point total derived from the DUCM is equal to or greater than 10. The following data sources shall be used to derive the point total in the DUCM:

- (1) The total annual project costs as stated in the DUCA;
- (2) The number of households in the unsewered community as stated in the DUCA;
- (3) The MHI of the unsewered community as found in the most recent American Community Survey or United States Census or as stated in an income survey that is conducted by the regulated entity or community and is based on the Iowa community development block grant income survey guidelines; and
- (4) The unemployment rate of the county where the unsewered community is located and of the state as found in the most recent Iowa Workforce Information Network unemployment data.

The ratio of the total annual project costs per household to MHI shall be calculated in the DUCM as follows: the total annual project costs shall be divided by the number of households in the unsewered community to obtain the costs per household, and the costs per household shall be divided by MHI to obtain the ratio.

f. Ratio and other considerations. The director shall not consider an unsewered community a disadvantaged unsewered community if the ratio of compliance costs to MHI is below 1 percent. The director shall consider an unsewered community a disadvantaged unsewered community if the ratio of compliance costs to MHI is greater than or equal to 2 percent. If the ratio of compliance costs to MHI is greater than or equal to 1 percent, and less than 2 percent, the director shall use the DUCM to determine if the unsewered community is disadvantaged. The ratio of compliance costs to MHI shall be the ratio of the total annual project costs per household to MHI as calculated in the DUCM. The director shall not require installation of a wastewater treatment system by an unsewered community if the director determines that such installation would create SWESI.

g. Compliance agreement for a disadvantaged unsewered community. A compliance agreement negotiated with a disadvantaged unsewered community as a result of SWESI shall require the unsewered community to submit an alternatives report and an alternatives implementation compliance plan (AICP).

(1) Alternatives report. The alternatives report must detail the alternative pollution control measures that will be investigated and contain an examination of all other appropriate measures that may achieve compliance with the water quality standards without creating SWESI. The alternatives report must describe which measures will be evaluated for feasibility and affordability after the report submittal. Alternative pollution control measures may include, but are not limited to, upgrades of existing infrastructure, construction of a new facility, relocation of the discharge point(s), regionalization, or outfall consolidation. Other appropriate measures may include, but are not limited to, mixing zone studies, consideration of seasonal limitations or site-specific data, alteration of current facility operations, intermittent discharges, source reduction, effluent recycling or reuse, or renegotiation of treatment agreements. The alternatives report shall also include a plan for pursuing funding options, including grants and low-interest loans. The alternatives report shall be submitted no later than two years after an unsewered community has been determined to be a disadvantaged unsewered community.

(2) Alternatives implementation compliance plan (AICP). The AICP shall include the results of the investigation detailed in the alternatives report, a description of any feasible and affordable alternative(s)

that will be implemented, a schedule of the time necessary to implement the alternative(s), and an updated DUCA. The AICP shall be submitted no later than 4½ years after an unsewered community has been determined to be a disadvantaged unsewered community.

(3) AICP implementation schedule. If the AICP proposes a schedule for implementation of one or more feasible alternatives, the proposed schedule shall be included in an administrative order between the department and the unsewered community. If the feasible alternative that will be implemented requires a construction permit, an operation permit, or an NPDES permit, the unsewered community shall comply with the rules regarding those permits in this chapter.

(4) Future compliance plan (FCP). The submittal of an FCP will be necessary only if the AICP concludes that the unsewered community cannot feasibly implement any alternatives and if the community is still disadvantaged according to the updated information in the DUCA submitted with the AICP. The FCP shall detail how the unsewered community will meet the water quality standards and the period necessary to do so. An FCP shall review the types of technology capable of treating the pollutant of concern, as well as the costs of installing and operating each type of technology. All technically feasible alternatives shall be explored. The FCP shall be submitted no later than seven years after an unsewered community has been determined to be a disadvantaged unsewered community. An administrative order requiring the submittal of an FCP shall also require the submittal of biennial progress reports that contain an updated DUCA. If the DUCM evaluation determines that an unsewered community is no longer disadvantaged based on the most recent DUCA, the order may be amended at the discretion of the director.

64.7(7) *Other terms and conditions of issued NPDES permits.* Each issued NPDES permit shall provide for and ensure the following:

a. That all discharges authorized by the NPDES permit shall be consistent with the terms and conditions of the permit; that facility expansions, production increases, or process modifications which result in new or increased discharges of pollutants must be reported by submission of a new NPDES application or, if such discharge does not violate effluent limitations specified in the NPDES permit, by submission to the director of notice of such new or increased discharges of pollutants; that the discharge of any pollutant more frequently than or at a level in excess of that identified and authorized by the permit shall constitute a violation of the terms and conditions of the permit; that if the terms and conditions of a general permit are no longer applicable to a discharge, the applicant shall apply for an individual NPDES permit;

b. That the permit may be amended, revoked and reissued, or terminated in whole or in part for the causes provided in 64.3(11) “*b.*”

c. That the permittee shall permit the director or the director’s authorized representative upon the presentation of credentials:

(1) To enter upon permittee’s premises in which an effluent source is located or in which any records are required to be kept under terms and conditions of the permit;

(2) To have access to and copy any records required to be kept under terms and conditions of the permit;

(3) To inspect any monitoring equipment or method required in the permit; or

(4) To sample any discharge of pollutants.

d. That, if the permit is for a discharge from a publicly owned treatment works, the permittee shall provide notice to the director of the following:

(1) One hundred eighty days in advance of any new introduction of pollutants into such treatment works from a new source as defined in 567—Chapter 60 if such source were discharging pollutants;

(2) Except as specified below, 180 days in advance of any new introduction of pollutants into such treatment works from a source which would be subject to Section 301 of the Act if such source were discharging pollutants. However, the connection of such a source need not be reported if the source contributes less than 25,000 gallons of process wastewater per day at the average discharge, or contributes less than 5 percent of the organic or hydraulic loading of the treatment facility, or is not subject to a federal pretreatment standard adopted by reference in 567—Chapter 62, or does not contribute pollutants that may cause interference or pass through; and

(3) Sixty days in advance of any substantial change in volume or character of pollutants being introduced into such treatment works by a source introducing pollutants into such works at the time of issuance of the permit.

Such notice shall include information on the quality and quantity of effluent to be introduced into such treatment works and any anticipated impact of such change in the quantity or quality of effluent to be discharged from such publicly owned treatment works.

e. That, if the permit is for a discharge from a publicly owned treatment works, the permittee shall require any industrial user of such treatment works to comply with the requirements of Sections 204(b), 307, and 308 of the Act. As a means of ensuring such compliance, the permittee shall require that each industrial user subject to the requirements of Section 307 of the Act give to the permittee periodic notice (over intervals not to exceed six months) of progress toward full compliance with Section 307 requirements. The permittee shall forward a copy of the notice to the director.

f. That the permittee at all times shall maintain in good working order and operate as efficiently as possible any facilities or systems of treatment and control which have been installed or are used by the permittee to achieve compliance with the terms and conditions of the permit. Proper operation and maintenance also include adequate laboratory control and appropriate quality assurance procedures. This provision requires the operation of backup or auxiliary facilities or similar systems which have been installed by the permittee only when such operation is necessary to achieve compliance with the conditions of the permit.

g. That if a toxic effluent standard or prohibition (including any schedule of compliance specified in such effluent standard or prohibition) is established under Section 307(a) of the Act for a toxic pollutant which is present in the permittee's discharge and such standard or prohibition is more stringent than any limitation upon such pollutant in the NPDES permit, the director shall revise or modify the permit in accordance with the toxic effluent standard or prohibition and so notify the permittee.

h. If an applicant for an NPDES permit proposes to dispose of pollutants into wells as part of a program to meet the proposed terms and conditions of an NPDES permit, the director shall specify additional terms and conditions of the issued NPDES permit which shall prohibit the proposed disposal or control the proposed disposal in order to prevent pollution of ground and surface water resources and to protect the public health and welfare. (See rule 567—62.9(455B) which prohibits the disposal of pollutants, other than heat, into wells within Iowa.)

i. That the permittee shall take all reasonable steps to minimize or prevent any discharge in violation of the permit which has a reasonable likelihood of adversely affecting human health or the environment.

j. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the terms of this permit.

64.7(8) *POTW compliance—plan of action required.* The owner of a publicly owned treatment works (POTW) must prepare and implement a plan of action to achieve and maintain compliance with final effluent limitations in its NPDES permit, as specified below:

a. The director shall notify the owner of a POTW of the plan of action requirement, and of an opportunity to meet with department staff to discuss the plan of action requirements. The POTW owner shall submit a plan of action to the appropriate regional field office of the department within six months of such notice, unless a longer time is needed and is authorized in writing by the director.

b. The plan of action will vary in length and complexity depending on the compliance history and physical status of the particular POTW. It must identify the deficiencies and needs of the system, describe the causes of such deficiencies or needs, propose specific measures (including an implementation schedule) that will be taken to correct the deficiencies or meet the needs, and discuss the method of financing the improvements proposed in the plan of action. A plan may include the submittal of a disadvantaged community analysis in accordance with subrule 64.7(5), at the discretion of the POTW.

The plan may provide for a phased construction approach to meet interim and final limitations, where financing is such that a long-term project is necessary to meet final limitations, and shorter term projects may provide incremental benefits to water quality in the interim.

Information on the purpose and preparation of the plan can be found in the departmental document entitled "Guidance on Preparing a Plan of Action," available from the department's regional field offices.

c. Upon submission of a complete plan of action to the department, the plan should be reviewed and approved or disapproved within 60 days unless a longer time is required and the POTW owner is so notified.

d. The NPDES permit for the facility shall be amended to include the implementation schedule or other actions developed through the plan to achieve and maintain compliance.

This rule is intended to implement Iowa Code chapter 455B, division III, part 1 (455B.171 to 455B.187).

[ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 0529C, IAB 12/12/12, effective 1/16/13]

567—64.8(455B) Reissuance of operation and NPDES permits.

64.8(1) *Individual operation and NPDES permits.* Individual operation and NPDES permits will be reissued according to the procedures identified in 64.8(1) "a" to "c."

a. Any operation or NPDES permittee who wishes to continue to discharge after the expiration date of the permit shall file an application for reissuance of the permit at least 180 days prior to the expiration of the permit pursuant to 567—60.4(455B). For a POTW, permission to submit an application at a later date may be granted by the director. In addition, the applicant must submit or have submitted information to show:

(1) That the permittee is in compliance or has substantially complied with all the terms, conditions, requirements and schedules of compliance of the expiring operation or NPDES permit.

(2) Up-to-date information on the permittee's production levels, permittee's waste treatment practices, nature, contents, and frequency of permittee's discharge.

(3) That the discharge is consistent with applicable effluent standards and limitations, water quality standards and other legally applicable requirements listed in 64.7(2), including any additions to, or revision or modifications of, such effluent standards and limitations, water quality standards, or other legally applicable requirements during the term of the permit.

b. The director shall follow the notice and public participation procedures specified in 567—64.5(455B) in connection with each request for reissuance of an NPDES permit.

c. Notwithstanding any other provision in these rules, any new point source the construction of which is commenced after the date of enactment of the Federal Water Pollution Control Act Amendments of 1972 (October 18, 1972) and which is so constructed as to meet all applicable standards of performance for new sources shall not be subject to any more stringent standard of performance during a ten-year period beginning on the date of completion of such construction or during the period of depreciation or amortization of such facility for the purposes of Section 167 or 169 (or both) of the Internal Revenue Code, as amended through December 31, 1976, whichever period ends first.

64.8(2) *Renewal of coverage under a general permit.* Coverage under a general permit will be renewed subject to the terms and conditions in paragraphs "a" to "d."

a. If a permittee intends to continue an activity covered by a general permit beyond the expiration date of the general permit, the permittee must reapply and submit a complete Notice of Intent in accordance with 64.6(1).

b. A complete Notice of Intent for coverage under a reissued or renewed general permit must be submitted to the department within 180 days after the expiration date of a general permit.

c. A person holding a general permit is subject to the terms of the permit until it expires or a Notice of Discontinuation is submitted in accordance with 64.6(5). If the person holding a general permit continues the activity beyond the expiration date, the conditions of the expired general permit will remain in effect provided the permittee submits a complete Notice of Intent for coverage under a renewed or reissued general permit within 180 days after the expiration date of the expired general permit. If the person continues an activity for which the general permit has expired and the general permit has not been reissued or renewed, the discharge must be permitted with an individual NPDES permit according to the procedures in 64.3(4) "a."

d. The Notice of Intent requirements shall not include a public notification when a general permit has been reissued or renewed provided the permittee has already submitted a complete Notice of Intent including the public notification requirements of 64.6(1). Another public notice is required when any information, including facility location, in the original public notice is changed.

64.8(3) Continuation of expiring operation and NPDES permits.

a. The conditions of an expired operation or NPDES permit will continue in force until the effective date of a new permit if:

- (1) The permittee has submitted a complete application under 567—subrule 60.4(2); and
- (2) The department, through no fault of the permittee, does not issue a new permit with an effective date on or before the expiration date of the previous permit.

b. Operation and NPDES permits continued under this subrule remain fully effective and enforceable.

c. If a permittee is not in compliance with the conditions of the expiring or expired permit, the department may choose to do any of the following:

- (1) Initiate enforcement action on the permit which has been continued;
- (2) Issue a notice of intent to deny a permit under 64.5(1);
- (3) Reissue a permit with appropriate conditions in accordance with this subrule; or
- (4) Take other actions authorized by this rule.

[ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 9365B, IAB 2/9/11, effective 3/30/11]

567—64.9(455B) Monitoring, record keeping and reporting by operation permit holders. Operation permit holders are subject to any applicable requirements and provisions specified in the operation permit issued by the department.

[ARC 7625B, IAB 3/11/09, effective 4/15/09]

567—64.10(455B) Silvicultural activities. The following is adopted by reference: 40 CFR 122.27.

[ARC 7625B, IAB 3/11/09, effective 4/15/09]

567—64.11 and 64.12 Reserved.

567—64.13(455B) Storm water discharges.

64.13(1) The following is adopted by reference: 40 CFR 122.26.

64.13(2) Small municipal separate storm sewer systems.

a. For any discharge from a regulated small municipal separate storm sewer system (MS4), the permit application must be submitted no later than March 10, 2003, if designated under this subrule.

b. All MS4s located in urbanized areas as defined by the latest decennial census and all MS4s which serve 10,000 people or more located outside urbanized areas and where the average population density is 1,000 people/square mile or more are regulated small MS4s unless waiver criteria established by the department are met and a waiver has been granted by the department.

c. Permit coverage requirements for MS4s located in urbanized areas and serving 1,000 or more people and fewer than 10,000 people may be waived if the following requirements are met:

(1) The department has evaluated all waters of the United States that receive a discharge from the MS4, and for all such waters, the department has determined that storm water controls are not needed based on wasteload allocations that are part of an EPA approved or established total maximum daily load (TMDL) that addresses the pollutants of concern or, if a TMDL has not been developed or approved, an equivalent analysis that determines sources and allocations for the pollutants of concern. The pollutants of concern include biochemical oxygen demand, sediment or a parameter that addresses sediment (total suspended solids, turbidity or siltation), pathogens, oil and grease, and any pollutant that has been identified as a cause of impairment of any water body that will receive a discharge from the MS4.

(2) The department has determined that future discharges from the MS4 do not have the potential to result in exceedances of water quality standards, including impairment of designated uses or other significant water quality impacts including habitat and biological impacts.

d. Permit coverage requirements for MS4s located in urbanized areas and serving fewer than 1,000 people may be waived if the following requirements are met:

(1) The system is not contributing substantially to the pollutant loadings of a physically interconnected MS4 that is regulated by the NPDES storm water program.

(2) The MS4 discharges any pollutants that have been identified as a cause of impairment of any water body to which the MS4 discharges and the department has determined that storm water controls are not needed based upon wasteload allocations that are a part of an EPA approved or established TMDL that addresses the pollutants of concern.

e. Permit coverage requirements for MS4s located outside of urbanized areas and serving 10,000 or more people may be waived if the following criterion is met:

The MS4 is not discharging pollutants which are the cause of the impairment to a water body designated by the department as impaired.

f. Should conditions under which the initial waiver was granted change, the waiver may be rescinded by the department and permit coverage may be required.

g. MS4 applications shall, at a minimum, demonstrate in what manner the applicant will develop, implement and enforce a storm water management program designed to reduce the discharge of pollutants from the MS4 to the maximum extent practicable, to protect water quality and to satisfy the appropriate water quality requirements of the Clean Water Act. The manner in which the permittee will address the following items must be addressed in the application: public education and outreach on storm water impacts, public involvement and participation, illicit discharge detection and elimination, construction site storm water runoff control, postconstruction storm water management in new development and redevelopment, and pollution prevention for municipal operations. Measurable goals which the applicant intends to meet and dates by which the goals will be accomplished shall be included with the application.

64.13(3) Waivers for storm water discharge associated with small construction activity. The director may waive the otherwise applicable requirements in a general permit for storm water discharge from small construction activities as defined in 567—Chapter 60 when:

a. The value of the rainfall erosivity factor (“R” in the Revised Universal Soil Loss Equation) is less than 5 during the period of construction activity. The rainfall erosivity factor is determined in accordance with Chapter 2 of Agriculture Handbook Number 703, Predicting Soil Erosion by Water: A Guide to Conservation Planning With the Revised Universal Soil Loss Equation (RUSLE), pages 21-64, dated January 1997; or

b. Storm water controls are not needed based on a TMDL approved or established by the EPA that addresses the pollutant(s) of concern or, for nonimpaired waters that do not require TMDLs, an equivalent analysis that determines allocations for small construction sites for the pollutant(s) of concern or that determines that such allocations are not needed to protect water quality based on consideration of existing in-stream concentrations, expected growth in pollutant contributions from all sources, and a margin of safety. The pollutant(s) of concern includes sediment or a parameter that addresses sediment (such as total suspended solids, turbidity or siltation) and any other pollutant that has been identified as a cause of impairment of any water body that will receive a discharge from the construction activity.

[ARC 7625B, IAB 3/11/09, effective 4/15/09]

567—64.14(455B) Transfer of title and owner or operator address change. If title to any disposal system or part thereof for which a permit has been issued under 567—64.2(455B), 567—64.3(455B) or 567—64.6(455B) is transferred, the new owners shall be subject to all terms and conditions of said permit. Whenever title to a disposal system or part thereof is changed, the department shall be notified in writing of such change within 30 days of the occurrence. No transfer of the authorization to discharge from the facility represented by the permit shall take place prior to notifying the department of the transfer of title. Whenever the address of the owner is changed, the department shall be notified in writing within 30 days of the address change. Electronic notification is not sufficient; all title transfers or address changes must be reported to the department by mail.

64.14(1) *Permits issued under rule 567—64.2(455B), 567—64.3(455B), or 567—64.6(455B), except 64.6(1)“a”(5).* If title to any disposal system or part thereof for which a permit has been issued is transferred, the new owners shall be subject to all terms and conditions of the permit. Whenever title to a disposal system or part thereof is changed, the department shall be notified in writing of such change within 30 days of the occurrence. No transfer of the authorization to discharge from the facility represented by the permit shall take place prior to notification of the department of the transfer of title. Whenever the address of the owner is changed, the department shall be notified in writing within 30 days of the address change. Electronic notification is not sufficient; all title transfers and address changes must be reported to the department by mail.

64.14(2) *Permits issued under 64.6(1)“a”(5).* When the operator of a facility changes, the department must be notified of the transfer within 30 days. When a discharge is covered by the general permit, the operator of record shall be subject to all terms and conditions of the permit. No transfer of the authorization to discharge from the facility represented by the permit shall take place prior to notification of the department of the transfer. Whenever the address of the operator is changed, the department shall be notified in writing within 30 days of the address change. Electronic notification is not sufficient; all transfers and address changes must be reported to the department by mail.

[ARC 7625B, IAB 3/11/09, effective 4/15/09; ARC 9553B, IAB 6/15/11, effective 7/20/11]

Rules 567—64.3(455B) to 567—64.14(455B) are intended to implement Iowa Code section 455B.173.

567—64.15(455B) General permits issued by the department. The following is a list of general permits adopted by the department through the Administrative Procedure Act, Iowa Code chapter 17A, and the term of each permit.

64.15(1) Storm Water Discharge Associated with Industrial Activity, NPDES General Permit No. 1, effective October 1, 2012, to October 1, 2017, as amended on March 26, 2014. Facilities assigned Standard Industrial Classification 1442, 2951, or 3273, and those facilities assigned Standard Industrial Classification 1422 or 1423 which are engaged primarily in rock crushing are not eligible for coverage under General Permit No. 1.

64.15(2) Storm Water Discharge Associated with Industrial Activity for Construction Activities, NPDES General Permit No. 2, effective October 1, 2012, to October 1, 2017, as amended on August 12, 2015.

64.15(3) Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, Rock Crushing Plants, and Construction Sand and Gravel Facilities, NPDES General Permit No. 3, effective October 1, 2012, to October 1, 2017, as amended on March 26, 2014. General Permit No. 3 authorizes storm water discharges from facilities primarily engaged in manufacturing asphalt paving mixtures and which are classified under Standard Industrial Classification 2951, primarily engaged in manufacturing Portland cement concrete and which are classified under Standard Industrial Classification 3273, those facilities assigned Standard Industrial Classification 1422 or 1423 which are primarily engaged in the crushing, grinding or pulverizing of limestone or granite, and construction sand and gravel facilities which are classified under Standard Industrial Classification 1442. General Permit No. 3 does not authorize the discharge of water resulting from dewatering activities at rock quarries.

64.15(4) “Discharge from Private Sewage Disposal Systems,” NPDES General Permit No. 4, effective March 18, 2009, to March 17, 2011.

64.15(5) “Discharge from Mining and Processing Facilities,” NPDES General Permit No. 5, effective July 20, 2011.

64.15(6) “Discharge Associated with Well Construction Activities,” NPDES General Permit No. 6, effective March 1, 2015, to February 28, 2020.

64.15(7) “Pesticide General Permit (PGP) for Point Source Discharges to Waters of the United States From the Application of Pesticides,” NPDES General Permit No. 7, effective March 30, 2011, to March 29, 2016.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 8520B, IAB 2/10/10, effective 3/17/10; ARC 9365B, IAB 2/9/11, effective 3/30/11; ARC 9553B, IAB 6/15/11, effective 7/20/11; ARC 0261C, IAB 8/8/12, effective 10/1/12; ARC 1337C, IAB 2/19/14, effective 3/26/14; ARC 1912C, IAB 3/18/15, effective 3/1/15; ARC 2054C, IAB 7/8/15, effective 8/12/15]

567—64.16(455B) Fees.

64.16(1) A person who applies for an individual permit or coverage under a general permit to construct, install, modify or operate a disposal system shall submit along with the application an application fee or a permit fee or both as specified in 64.16(3). Certain individual facilities shall also be required to submit annual fees as specified in 64.16(3) “b.” Fees shall be assessed based on the type of permit coverage the applicant requests, either as general permit coverage or as an individual permit. For a construction permit, an application fee must be submitted with the application. For General Permits Nos. 1, 2, 3 and 5, the applicant has the option of paying an annual permit fee or a multiyear permit fee at the time the Notice of Intent for coverage is submitted.

For individual storm water only permits, a one-time, multiyear permit fee must be submitted at the time of application. A storm water only permit is defined as an NPDES permit that authorizes the discharge of only storm water and any allowable non-storm water as defined in the permit. For all other non-storm water NPDES permits and operation permits, the applicant must submit an application fee at the time of application and the appropriate annual fee on a yearly basis. A non-storm water NPDES permit is defined as any individual NPDES permit or operation permit issued to a municipality, industry, semipublic entity, or animal feeding operation that is not an individual storm water only permit. If a facility needs coverage under more than one NPDES permit, fees for each permit must be submitted appropriately.

Fees are nontransferable. If the application is returned to the applicant by the department, the permit fee will be returned. No fees will be returned if the permit or permit coverage is suspended, revoked, or modified, or if the activity is discontinued. Failure to submit the appropriate fee at the time of application renders the application incomplete, and the department shall suspend processing of the application until the fee is received. Failure to submit the appropriate annual fee may result in revocation or suspension of the permit as noted in 64.3(11) “f.”

64.16(2) Payment of fees. Fees shall be paid by check or money order made payable to the “Iowa Department of Natural Resources.”

For facilities needing coverage under both a storm water only permit and a non-storm water NPDES permit, separate payments shall be made according to the fee schedule in 64.16(3).

64.16(3) Fee schedule. The following fees have been adopted:

a. For coverage under the NPDES general permits, the following fees apply:

(1) Storm Water Discharges Associated with Industrial Activity, NPDES General Permit No. 1.

Annual Permit Fee \$175(per year)

or

Five-year Permit Fee \$700

Four-year Permit Fee \$525

Three-year Permit Fee \$350

All fees are to be submitted with the Notice of Intent for coverage under the general permit.

(2) Storm Water Discharge Associated with Industrial Activity for Construction Activities, NPDES General Permit No. 2. The fees are the same as those specified for General Permit No. 1 in subparagraph (1) of this paragraph.

(3) Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, and Rock Crushing Plants, NPDES General Permit No. 3. The fees are the same as those specified for General Permit No. 1 in subparagraph (1) of this paragraph.

(4) Discharge from Private Sewage Disposal Systems, NPDES Permit No. 4. No fees shall be assessed.

(5) Discharge from Mining and Processing Facilities, NPDES General Permit No. 5.

Annual Permit Fee	\$125 (per year)
or	
Five-year Permit Fee	\$500
Four-year Permit Fee	\$400
Three-year Permit Fee	\$300

New facilities seeking General Permit No. 5 coverage shall submit fees with the Notice of Intent for coverage. Maximum coverage is for five years. Coverage may also be obtained for four years, three years, or one year, as shown in the fee schedule above. Existing facilities shall submit annual fees by August 30 of every year, unless a multiyear fee payment was received in an earlier year. In the event a facility is no longer eligible to be covered under General Permit No. 5, the remainder of the fees previously paid by the facility shall be applied toward its individual permit fees.

b. Individual NPDES and operation permit fees. The following fees are applicable for the described individual NPDES permit:

(1) For permits that authorize the discharge of only storm water associated with industrial activity and any allowable non-storm water, a five-year permit fee of \$1,250 must accompany the application.

(2) For permits that authorize the discharge of only storm water from municipal separate storm sewer systems and any allowable non-storm water, a five-year permit fee of \$1,250 must accompany the application.

(3) For operation and non-storm water NPDES permits not subject to subparagraphs (1) and (2), a single application fee of \$85 as established in Iowa Code section 455B.197 is due at the time of application. The application fee is to be submitted with the application forms (as required by 567—Chapter 60) at the time of a new application, renewal application, or amendment application. Before an approved amendment request submitted by a facility holding a non-storm water NPDES permit can be processed by the department, the application fee must be submitted. Application fees will not be charged to facilities holding non-storm water NPDES permits when an amendment request is initiated by the director, when the requested amendment will correct an error in the permit, or when there is a transfer of title or change in the address of the owner as noted in 567—64.14(455B).

(4) For every major and minor municipal facility, every semipublic facility, every major and minor industrial facility, every facility that holds an operation permit (no wastewater discharge into surface waters), and every open feedlot animal feeding operation required to hold a non-storm water NPDES permit, an annual fee as established in Iowa Code section 455B.197 is due by August 30 of each year.

(5) For every municipal water treatment facility with a non-storm water NPDES permit, no fee is charged (as established in Iowa Code section 455B.197).

(6) For a new facility, an annual fee as established in Iowa Code section 455B.197 is due 30 days after the new permit is issued.

c. Wastewater construction permit fees. A single construction permit fee as established in Iowa Code section 455B.197 is due at the time of construction permit application submission.

64.16(4) Fee refunds for storm water general permit coverage—pilot project. Rescinded IAB 10/16/02, effective 11/20/02.

64.16(5) “Discharge Associated with Well Construction Activities,” NPDES General Permit No. 6. No fees shall be assessed.

64.16(6) “Pesticide General Permit (PGP) for Point Source Discharges to Waters of the United States From the Application of Pesticides,” NPDES General Permit No. 7. No fees shall be assessed.

[Editorial change: IAC Supplement 2/11/09; **ARC 7625B**, IAB 3/11/09, effective 4/15/09; **ARC 8520B**, IAB 2/10/10, effective 3/17/10; **ARC 9365B**, IAB 2/9/11, effective 3/30/11; **ARC 9553B**, IAB 6/15/11, effective 7/20/11]

567—64.17(455B) Validity of rules. If any section, paragraph, sentence, clause, phrase or word of these rules, or any part thereof, be declared unconstitutional or invalid for any reason, the remainder of said rules shall not be affected thereby and shall remain in full force and effect.

567—64.18(455B) Applicability. This chapter shall apply to all waste disposal systems treating or intending to treat sewage, industrial waste, or other waste except waste resulting from livestock or poultry operations. All livestock and poultry operations constituting animal feeding operations as defined in 567—Chapter 65 shall be governed by the requirements contained in Chapter 65. However, the provisions of this chapter concerning NPDES permits which relate to notice and public participation, to the terms and conditions of the permit, to the reissuance of the permit and to monitoring, reporting and record-keeping activities shall apply to animal feeding operations which are required to apply for and obtain an NPDES permit to the extent that such requirements are not inconsistent with 567—Chapter 65. [ARC 1627C, IAB 9/17/14, effective 10/22/14]

These rules are intended to implement Iowa Code chapter 455B, division III, part 1.

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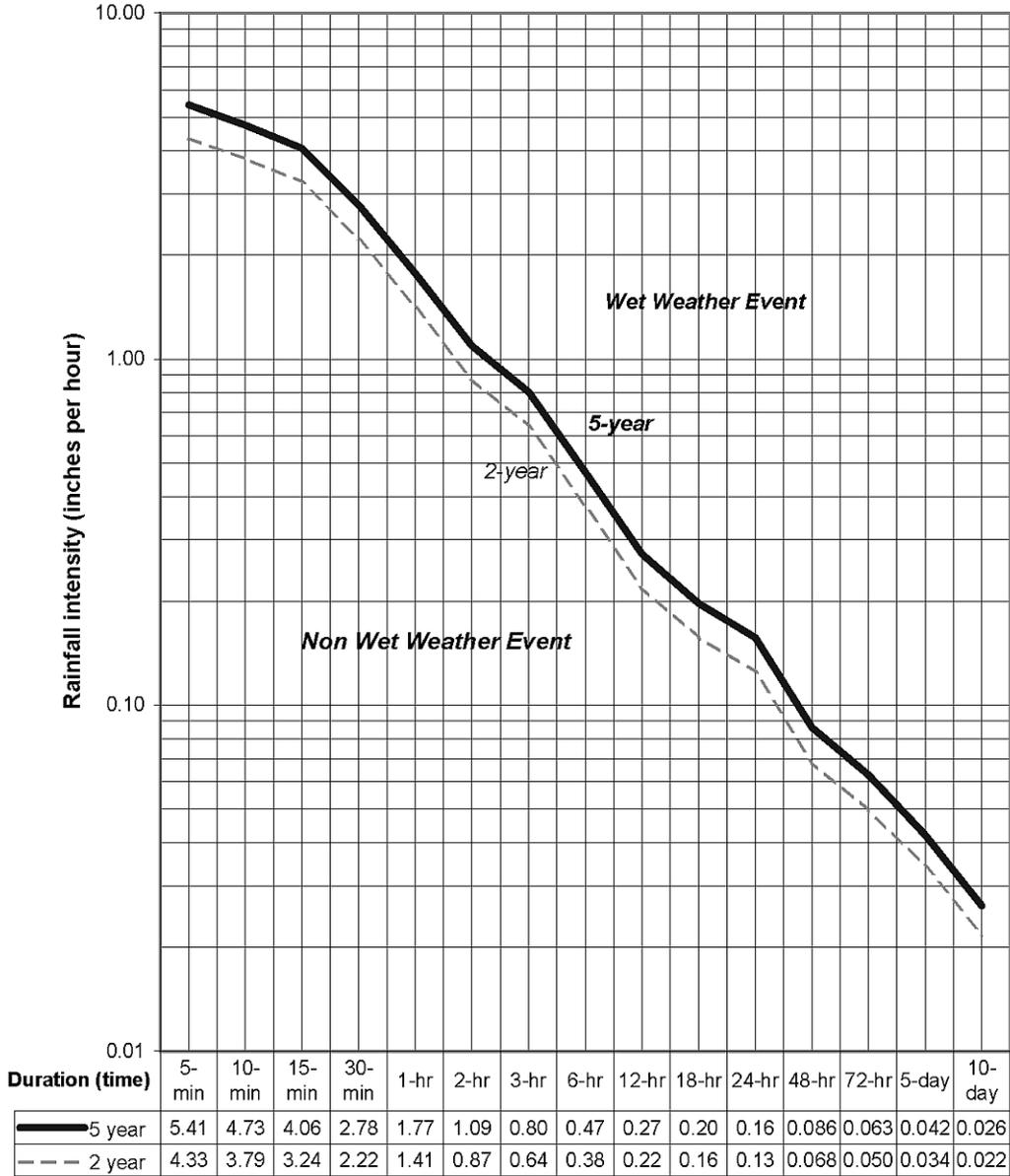
[Filed Emergency After Notice ARC 1912C (Notice ARC 1757C, IAB 12/10/14), IAB 3/18/15,
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¹ Effective date of 64.2(9)“c” delayed 70 days by the Administrative Rules Review Committee. The 70-day delay of effective date of 64.2(9)“c” was lifted by the Administrative Rules Review Committee on 7/31/86.

APPENDIX A Rainfall Intensity - Duration - Frequency Curve (5 and 2 year Return Intervals)

Data Source: Rainfall Frequency Atlas of the Midwest, Illinois State Water Survey, 1992.



Rainfall intensity data points (inches per hour)

[ARC 7625B, IAB 3/11/09, effective 4/15/09]

TITLE VI
PARKS AND RECREATION AREAS
CHAPTER 61
STATE PARKS, RECREATION AREAS, AND STATE FOREST CAMPING
[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 and by political subdivisions unless otherwise noted. This chapter also governs camping activity in the following state forests:

1. Shimek State Forest in Lee and Van Buren Counties.
2. Stephens State Forest in Appanoose, Clarke, Davis, Lucas and Monroe Counties.
3. Yellow River State Forest in Allamakee County.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

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.

“Commission” means the natural resource commission.

“Department” means the department of natural resources.

“Fishing” means taking or attempting to take fish by utilizing hook, line and bait as described 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 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 any of the following: 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 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
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, warming lodges, 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 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

<u>Area</u>	<u>County</u>
Red Haw	Lucas
Rice Lake	Winnebago
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
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 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
Oak Grove	Sioux

<u>Area</u>	<u>County</u>
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
Gitchie Manitou	Lyon

<u>Area</u>	<u>County</u>
Glenwood	Mills
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
Perkins Prairie	Greene
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
Savage Woods	Henry
Searryl's Cave	Jones
Sheeder Prairie	Guthrie

<u>Area</u>	<u>County</u>
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
Vincent Bluff	Pottawattamie
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; ARC 0383C, IAB 10/3/12, effective 11/7/12]

DIVISION I
STATE PARKS AND RECREATION AREAS

571—61.3(461A) Centralized reservation system—operating procedures and policies. The centralized reservation system of the department accepts and processes reservations for camping and rental facilities in state parks, recreation areas and state forest campgrounds.

61.3(1) Recreation facilities available on centralized reservation system.

a. Rental facilities. All rental facilities are available on the centralized reservation system with the exception of the conservation education center rental at Springbrook State Park.

b. Campgrounds.

(1) All campgrounds are 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 are included in the reservation system.

(4) Reservations will not be accepted for camping stays that occur November 1 through March 31.

61.3(2) *Methods available to make reservations.* Persons may make reservations by telephone through the call center or through the Internet by using the reservation system Web site.

61.3(3) *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 per 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 fees, which differ based upon the method used when the reservation is made, are as follows:

(1) Internet reservation — \$4.

(2) Telephone reservation — \$6.

b. Change fee. The following fees 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. The following fees 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(4) *Reservation window.*

a. Camping. Camping reservations may be made up to 3 months before arrival but no later than 21 days before arrival if payment is made by paper check or money order and no later than 2 days before arrival if payment is made by credit card or debit card.

b. Rental facilities.

(1) Rentals for May 1 to September 30. Rental facility reservations may be made up to 12 months before arrival but not later than 21 days before arrival if payment is made by paper check or money order and no later than 4 days before arrival if payment is made by credit card or debit card.

(2) Rentals for October 1 to April 30. Rental facility reservations may be made up to 12 months before arrival but not later than 21 days before arrival if payment is made by paper check or money order and no later than 7 days before arrival if payment is made by credit card or debit card.

61.3(5) *Site-specific reservations.* All reservations shall be for a specific campsite, cabin, lodge or open shelter.

61.3(6) *Changing a reservation.* Changes to reservations shall not be made until the initial reservation has been paid in full.

a. Camping.

(1) The last day a person may make a change to a camping reservation is 4 days prior to the scheduled arrival date if payment is made by credit card or debit card or 21 days prior to the scheduled arrival date if payment is made by paper check or money order.

(2) Equestrian campers may make changes to a camping reservation less than 4 days prior to the arrival date if the equestrian trails are closed on the same day as the equestrian campers' scheduled arrival date or on the day before their scheduled arrival date.

b. Rental facilities. The last day a person may make a change to a rental facility reservation is 15 days prior to the scheduled arrival date if payment is made by credit card or debit card or 21 days prior to the scheduled arrival date if payment is made by paper check or money order.

61.3(7) *Canceling a reservation.* Persons who cancel their reservations prior to or on the scheduled arrival date shall receive a refund as follows:

a. Camping.

(1) Persons who cancel their reservations two or more days prior to the scheduled arrival date will receive a refund of all camping fees paid less the cancellation fee.

(2) Persons who cancel their reservations one day prior to the scheduled arrival date will receive a refund of all camping fees paid less the cancellation fee and forfeiture of one night's camping fee.

(3) Persons who cancel their reservations on the scheduled day of arrival will receive a refund of all camping fees paid less the cancellation fee and forfeiture of two nights' camping fees.

b. Cabins.

(1) Persons who cancel their reservations 30 or more days prior to the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee.

(2) Persons who cancel their reservations 15 to 29 days prior to the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee and forfeiture of one night's rental fee and tax.

(3) Persons who cancel their reservations less than 15 days prior to the scheduled arrival date or on the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee and forfeiture of two nights' rental fees and tax.

c. Lodges, open shelters, open shelters with kitchenettes, and beach house open shelters.

(1) Persons who cancel their reservations 30 or more days prior to the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee.

(2) Persons who cancel their reservations 15 to 29 days prior to the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee and forfeiture of one day's rental fee and tax.

(3) Persons who cancel their reservations less than 15 days prior to the scheduled arrival date or on the scheduled arrival date will receive a refund of all rental fees and tax paid less the cancellation fee and forfeiture of two days' rental fees and tax, if applicable.

d. Cancellation after scheduled arrival date. Persons who cancel any reservation after the scheduled arrival date will receive no refund unless extenuating circumstances have been documented, reviewed, and approved in writing by the department.

e. Cancellation fees exceeding camping or rental fees. When the cancellation fee and forfeiture of camping fees or rental fees and tax exceed the total amount of camping fees or rental fees and tax paid, no refund will be issued.

[ARC 9324B, IAB 1/12/11, effective 2/16/11; ARC 0383C, IAB 10/3/12, effective 11/7/12]

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. 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. The following fees shall be in effect from May 1 to September 30 each year.</i>			
Nonmodern	\$ 8.49	.51	\$ 9.00
Modern	10.38	.62	11.00
<i>b. The following fees shall be in effect from October 1 to April 30 each year.</i>			
Nonmodern	5.66	.34	6.00
Modern	7.55	.45	8.00

	<u>Fee</u>	<u>Sales Tax</u>	<u>Total Per Night</u>
c. 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).			
d. Organized youth group campsite, per group	14.15	.85	15.00
e. Cable television hookup	1.89	.11	2.00
f. Sewer and water hookup	2.83	.17	3.00
g. Additional fee for campgrounds designated for equestrian use	2.83	.17	3.00
This fee is in addition to applicable fees listed above.			
h. 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. 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. One copy of the registration form must then be placed in the campsite holder provided at the campsite. The camping length of stay identified on the camping registration form must begin with the actual date the camper registers, pays and posts the registration 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 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 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 program.

k. Minimum stay requirements for camping reservations. From May 1 to September 30, a two-night minimum stay is required for weekends. The two nights shall be designated as Friday and Saturday nights. However, if September 30 is a Friday, the Friday and Saturday night stay shall not apply. If September 30 is a Saturday, the Friday and Saturday night stay shall apply. The following additional exceptions apply:

(1) A Friday, Saturday, and Sunday night stay is required for the national Memorial Day holiday and national Labor Day holiday weekends.

(2) 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.

(3) A Friday, Saturday, and Sunday night stay is required for the Fourth of July holiday if the Fourth of July occurs on a Monday.

l. Buddy campsite reservations. Buddy campsites are between two to four individual sites that are grouped together and can only be reserved and used collectively. Campers reserving buddy campsites through the centralized reservation system must reserve both or all four of the individual sites that make up the group buddy campsite or buddy campsite.

m. 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.

n. 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 571—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; ARC 0383C, IAB 10/3/12, effective 11/7/12]

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. 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

	<u>Per Night*</u>	<u>Per Week</u>
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		
Camping cabins	35	210
Two-bedroom cabins	85	510
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
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

*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

	<u>Per Weekday</u> <u>M-Th***</u>	<u>Per Weekend Day</u> <u>Fr-Su</u>
Dolliver Memorial State Park, Webster County		
Central Lodge**	30	60
South Lodge	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		
Beach Lodge	35	70
Lodge	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		
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		
Lodge	35	70
Visitor Center Banquet Room	75	150
Mini-Wakan State Park, Dickinson County	75	150
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		
Rotary Lodge	35	70
Boy Scout Lodge	20	40
Waubonsie State Park, Fremont County	75	150

**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 rental. This fee does not include tax. Tax will be calculated at time of final payment.

	<u>Per Day</u>
Open shelter	\$25
Large open shelter	\$75
Big Creek State Park, Polk County (Beach Nos. 1-3)	
Brushy Creek State Recreation Area, Webster County (Lakeview Shelter)	
Lake Darling State Park, Washington County (Cottonwood Shelter)	
Open shelter with kitchen	\$75

	<u>Per Day</u>
Beach house open shelter	\$40
Lake Ahquabi State Park, Warren County	
Lake Wapello State Park, Davis County	
Pine Lake State Park, Hardin County	
Springbrook State Park, Guthrie County	
Beach cabana-style open shelter	\$15

e. 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.

f. 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 department 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.
- g. Pilot Knob warming house reservation, \$30 plus applicable tax.

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. A Friday, Saturday, and Sunday night stay is required for the national Memorial Day holiday and national Labor Day holiday weekends.

2. 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.

3. 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 a lodge, shelter, or beach house open shelter facility and all guests shall vacate the facility by 10 p.m.

61.5(4) Damage deposits for cabins, lodges, open shelters with kitchenettes, and yurts.

a. Upon arrival for the rental facility period, renters shall pay in full a damage deposit in an amount equal to the weekend daily rental fee for the facility or \$50, whichever is greater. If a gathering with keg beer takes place in a lodge or open shelter with kitchenette, the damage deposit shall be waived in lieu of a keg damage deposit as specified in 571—subrule 63.5(3) if the keg damage deposit is greater than the lodge or open shelter with kitchenette damage deposit.

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.

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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), 571—61.8(461A) and 571—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 department personnel in charge of the area.

d. Animals are prohibited in all park buildings, with the following exceptions:

- (1) Service dogs and assistive animals.
- (2) Dogs in designated cabins and yurts. A maximum of two dogs of any size shall be allowed in any designated cabin or yurt.
- (3) Animals being used in education and interpretation programs.

e. 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. Pets shall not be left unattended in campgrounds. Dogs shall be kenneled when left unattended in a cabin or yurt and shall not be left unattended if tied up outside of the cabin or yurt.

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, chainsaw use is prohibited in state parks and recreation areas. This provision is not applicable to employees of the department in the performance of their official duties.

61.7(5) Firearms. The use of firearms in state parks and recreation areas as defined in rule 571—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 rule 571—61.9(461A)), Volga River Recreation Area and Wilson Island Recreation Area.

b. Target and practice shooting in areas designated by the department.

c. Special events, festivals, and education programs sponsored or permitted by the department.

d. Special hunts authorized by the 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. 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. 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 any state park or recreation area 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 includes, but is not necessarily limited to, 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, public address system, or musical instrument. 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(1)“*c*” is permitted only during special hunts in state parks as provided under 571—Chapter 105 and as approved by the commission. During the dates of special hunts, only persons engaged in deer hunting shall use the area or portions thereof as designated by the department and signed as such.

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; ARC 0383C, IAB 10/3/12, effective 11/7/12]

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 571—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 department-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.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

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 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 571—61.9(461A) are prohibited in the Mines of Spain Recreation Area.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

571—61.10(461A) After-hours fishing—exception to closing time. Persons shall be allowed access to the areas designated in rule 571—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.
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.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

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 571—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.

The intended projects will be included in the department's annual five-year capital plan in priority order by year and approved by the 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.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

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(3) through 61.7(9) and 61.7(11) through 61.7(15) 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.

[ARC 0383C, IAB 10/3/12, effective 11/7/12; ARC 2052C, IAB 7/8/15, effective 9/15/15]

571—61.16 to 61.19 Reserved.

DIVISION II
STATE FOREST CAMPING

571—61.20(461A) Camping areas established and marked.

61.20(1) Areas to be utilized for camping shall be established within each of the state forests listed in rule 571—61.1(461A).

61.20(2) Signs designating the established camping areas shall be posted along the access roads into these areas and around the perimeter of the area designated for camping use.

61.20(3) Areas approved for backpack camping (no vehicular access) shall be marked with appropriate signs and shall contain fire rings.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

571—61.21(461A) Campground reservations. Procedures and policies regarding camping reservations in established state forest campgrounds shall be the same as those cited in rule 571—61.3(461A). Reservations will not be accepted for backpack campsites.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

571—61.22(461A) Camping fees and registration.

61.22(1) Fees.

a. Backpack campsites. No fee will be charged for the use of the designated backpack campsites.

b. The fees for camping in established state forest campgrounds shall be the same as those cited in paragraphs 61.4(1) "a" and "b" for all other nonmodern camping areas managed by the department where fees are charged.

61.22(2) Procedures for camping registration.

a. Backpack campsites. Persons using backpack campsites shall register at the forest area check station or other designated site.

b. The procedures for camping registration in established state forest campgrounds shall be the same as those cited in paragraphs 61.4(3) “a,” “b,” and “c.”

c. Organized youth group campsites. The procedures for camping registration for organized youth group campsites shall be the same as those cited in subrule 61.4(4).

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

571—61.23(461A) Restrictions—area and use.

61.23(1) Restrictions of campsite or campground use in established state forest campgrounds shall be the same as those cited in paragraphs 61.4(5) “a” through “c,” “e” through “k,” “m,” and “n.”

61.23(2) Hours. Access into and out of the established camping areas shall be permitted from 4 a.m. to 10:30 p.m. From 10:31 p.m. to 3:59 a.m., only registered campers are permitted in the campgrounds.

61.23(3) Firearms use prohibited. Except for peace officers acting in the scope of their employment, the use of firearms, fireworks, explosives, and weapons of all kinds by the public is prohibited within the established camping area as delineated by signs marking the area.

61.23(4) Pets. Pets such as dogs or cats shall not be allowed to run at large within established state forest camping areas. 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.

61.23(5) Noise. Subrule 61.7(9) shall apply to established state forest camping areas.

[ARC 0383C, IAB 10/3/12, effective 11/7/12]

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.

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◊ 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 1
ADMISSION RULES COMMON TO THE THREE STATE UNIVERSITIES
[Prior to 4/20/88, Regents, Board of[720]]

PREAMBLE

The state board of regents has adopted the following requirements governing admission of students to the three state universities.

Each university is expected to describe in its catalog the requirements and other information necessary to make the admission process operate within the framework of these requirements.

Amendments and changes in these requirements normally are proposed by the universities to the regent committee on educational relations, which examines the proposals and makes specific recommendations through the council of provosts to the state board of regents, which is empowered by law to establish the admission requirements.

The regent universities recognize that the traditional measures of academic performance do not adequately describe some students' potential for success. Therefore, the regent universities strongly encourage all interested students to apply for admission. Applicants who feel their academic record is not an accurate reflection of their potential for success are encouraged to provide supplemental information explaining their circumstances, in addition to the application, academic transcripts, and test scores.

[ARC 2051C, IAB 7/8/15, effective 8/12/15]

681—1.1(262) Admission of undergraduate students directly from high school. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

1.1(1) Application. Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(3) and detailed in rule 681—1.7(262), and have their secondary school provide a transcript of their academic record, including credits and grades, rank in class (when available), and certification of graduation. Applicants must also submit SAT Reasoning Test or ACT scores. Applicants whose primary language is not English must also meet the English language proficiency requirement specified by each university. Applicants may be required to submit additional information or data to support their applications.

1.1(2) Admission criteria.

a. Effective for students who seek admission prior to fall 2009. Graduates of approved Iowa high schools who have the subject matter background required by each university and who rank in the upper one-half of their graduating class will be admitted to any regent university. Applicants who are not in the upper one-half of their graduating class may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

- (1) Be admitted unconditionally,
- (2) Be admitted conditionally,
- (3) Be required to enroll for a tryout period during a preceding summer session, or
- (4) Be denied admission.

b. Effective for students who seek admission in fall 2009 and thereafter.

(1) Decisions on admission to a regent university are based on the following four factors: performance on standardized tests (SAT Reasoning Test or ACT); high school grade point average (GPA); high school percentile rank in class (when available); and number of high school courses completed in the core subject areas. A primary regent admission index (RAI) will be calculated for each freshman applicant using the formula below when the high school has provided a class rank.

$$\text{RAI} = \frac{(2 \times \text{ACT composite score})}{1} + \frac{(1 \times \text{high school rank expressed as a percentile})}{1} + \frac{(20 \times \text{high school grade point average})}{1} + \frac{(5 \times \text{number of high school courses completed in the core subject areas})}{1}$$

NOTE: For purposes of calculating the primary regent admission index, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents); high school rank is expressed as a percentile with 99 percent as the top value; high school GPA is expressed in a four-point scale; and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

(2) Graduates of approved Iowa high schools who have the subject matter background required by each university and who meet the regent admission index of 245 required for automatic admission will be admitted to any regent university. Applicants who do not meet the regent admission index of 245 for automatic admission or for whom a regent admission index cannot be calculated may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

1. Be admitted unconditionally,
2. Be admitted conditionally,
3. Be required to enroll for a tryout period during a preceding summer session, or
4. Be denied admission.

The regent universities recognize that the traditional measures of academic performance do not adequately describe some students' potential for success. Therefore, the regent universities strongly encourage all interested students to apply for admission. Applicants who feel their academic record is not an accurate reflection of their potential for success are encouraged to provide supplemental information explaining their circumstances, in addition to the application, academic transcripts, and test scores.

An alternative regent admission index (RAI) will be calculated for each freshman applicant using the equation below when the high school has not provided a class rank.

$$\text{RAI} = \frac{(3 \times \text{ACT composite score})}{1} + \frac{(30 \times \text{high school grade point average})}{1} + \frac{(5 \times \text{number of high school courses completed in the core subject areas})}{1}$$

NOTE: For purposes of calculating the alternative regent admission index, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents); high school GPA is expressed on a four-point scale; and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

Freshman applicants from Iowa high schools who have an RAI of at least 245 and who meet the minimum number of high school courses required by the regent universities will qualify for automatic admission to any of the three regent universities. Freshman applicants who have an RAI below 245 may also be admitted to a specific regent university; however, each regent university will review these applications on an individual basis, and admission decisions will be specific to each institution.

1.1(3) Graduates of approved high schools in other states may be held to higher academic standards, but must meet at least the same requirements as graduates of Iowa high schools. The options for conditional admission or summer tryout enrollment may not necessarily be offered to these students.

1.1(4) Applicants who are graduates of nonapproved high schools will be considered for admission in a manner similar to applicants from approved high schools, but additional emphasis will be given to scores obtained on standardized examinations.

1.1(5) Applicants who are not high school graduates, but whose classes have graduated, may be considered for admission. These applicants will be required to submit all academic data to the extent that it exists and achieve scores on standardized examinations which will demonstrate that they are adequately prepared for academic study.

1.1(6) Early admission.

a. Students with superior academic records may be admitted, on an individual basis, for part-time university study while enrolled in high school or during the summers prior to high school graduation.

b. In rare situations, exceptional students may be admitted as full-time students to a regent university before completing high school. Early admission to a regent university is provided to serve persons whose academic achievement and personal and intellectual maturity clearly suggest readiness for collegiate level study. Each university will specify requirements and conditions for early admission.

This rule is intended to implement Iowa Code section 262.9(3).
[ARC 2051C, IAB 7/8/15, effective 8/12/15]

681—1.2(262) Admission of undergraduate students by transfer from other colleges. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and request that each college they have attended send an official transcript of record to the admissions office. High school academic records and standardized test results may also be required. The Test of English as a Foreign Language (TOEFL) is required of foreign students whose first language is not English.

1.2(1) Transfer applicants with a minimum of 24 semester hours of graded credit from regionally accredited colleges or universities, who have achieved for all college work previously attempted the grade point required by each university for specific programs, will be admitted. Higher academic standards may be required of students who are not residents of Iowa.

Applicants who have not maintained the grade point required by each university for specific programs or who are under academic suspension from the last college attended may, after a review of their academic and test records, and at the discretion of the admissions officers:

- a. Be admitted unconditionally,
- b. Be admitted conditionally,
- c. Be required to enroll for a tryout period during a preceding summer session, or
- d. Be denied admission.

1.2(2) Admission of students with fewer than 24 semester hours of college credit will be based on high school academic and standardized test records in addition to review of the college record.

1.2(3) Transfer applicants under disciplinary suspension will not be considered for admission until information concerning the reason for the suspension has been received from the college assigning the suspension. Applicants granted admission under these circumstances will be admitted on probation.

1.2(4) Transfer applicants from colleges and universities not regionally accredited will be considered for admission on an individual basis taking into account all available academic information.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.3(262) Transfer credit practices. The regent universities endorse the Joint Statement on Transfer and Award of Academic Credit approved in 1978 by the American Council on Education (ACE), the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and the Council on Postsecondary Accreditation (COPA). The current issue of Transfer Credit Practices of Selected Educational Institutions, published by the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and publications of the Council on Postsecondary Accreditation (COPA) are examples of references used by the universities in determining transfer credit. The acceptance and use of transfer credit is subject to limitations in accordance with the educational policies operative at each university.

1.3(1) *Students from regionally accredited colleges and universities.* Credit earned at regionally accredited colleges and universities is acceptable for transfer except that credit in courses determined by the receiving university to be of a remedial, vocational, or technical nature, or credit in courses or programs in which the institution granting the credit is not directly involved, may not be accepted, or may be accepted to a limited extent.

Of the coursework earned at a two-year college, students may apply up to one-half but no more than 65 hours of the credits required for a bachelor's degree toward that degree at a regent university. This policy becomes effective September 29, 1993.

1.3(2) *Students from colleges and universities which have candidate status.* Credit earned at colleges and universities which have become candidates for accreditation by a regional association is acceptable for transfer in a manner similar to that from regionally accredited colleges and universities if the credit is applicable to the bachelor's degree at the receiving university.

Credit earned at the junior and senior classification from an accredited two-year college which has received approval by a regional accrediting association for change to a four-year college may be accepted by a regent university.

1.3(3) *Students from colleges and universities not regionally accredited.* When students are admitted from colleges and universities not regionally accredited, they may validate portions or all of their transfer credit by satisfactory academic study in residence, or by examination. Each university will specify the amount of the transfer credit and the terms of the validation process at the time of admission.

In determining the acceptability of transfer credit from private colleges in Iowa which do not have regional accreditation, the regent committee on educational relations, upon request from the institutions, evaluates the nature and standards of the academic program, faculty, student records, library, and laboratories.

In determining the acceptability of transfer credit from colleges in states other than Iowa which are not regionally accredited, acceptance practices indicated in the current issue of Transfer Credit Practices of Selected Educational Institutions will be used as a guide. For institutions not listed in the publication, guidance is requested from the designated reporting institution of the appropriate state.

1.3(4) *Students from foreign colleges and universities.* Transfer credit from foreign educational institutions may be granted after a determination of the type of institution involved and after an evaluation of the content, level, and comparability of the study to courses and programs at the receiving university. Credit may be granted in specific courses, but is frequently assigned to general areas of study. Extensive use is made of professional journals and references which describe the education systems and programs of individual countries.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.4(262) Classification of residents and nonresidents for admission, tuition, and fee purposes.

1.4(1) General.

a. A person enrolling at one of the three state universities shall be classified as a resident or nonresident for admission, tuition, and fee purposes by the registrar or someone designated by the registrar. The decision shall be based upon information furnished by the student and other relevant information.

b. In determining resident or nonresident classification, the issue is essentially one of why the person is in the state of Iowa. If the person is in the state primarily for educational purposes, that person will be considered a nonresident. For example, it may be possible that an individual could qualify as a resident of Iowa for such purposes as voting, or holding an Iowa driver's license, and not meet the residency requirements as established by the board of regents for admission, tuition, and fee purposes.

c. The registrar, or designated person, is authorized to require written documents, affidavits, verifications, or other evidence deemed necessary to determine why a student is in Iowa. The burden of establishing that a student is in Iowa for other than educational purposes is upon the student.

A student may be required to file any or all of the following:

- (1) A statement from the student describing employment and expected sources of support;
- (2) A statement from the student's employer;
- (3) A statement from the student's parents verifying nonsupport and the fact that the student was not listed as a dependent on tax returns for the past year and will not be so listed in future years;
- (4) A statement from the student's spouse related to sources of family support, length of residence in Iowa, and reasons for being in the state of Iowa;
- (5) Supporting statements from persons who might be familiar with the family situation;

(6) Iowa state income tax return.

d. Applications for resident classification for a given semester or session are due no later than the fifteenth class day of that semester or session. Applications received after the fifteenth class day of that semester or session will be considered for the next semester or session. Appeals of any nonresident classification decision resulting from applications for resident classifications are due no later than midterm of that semester or session. Change of classification from nonresident to resident will not be made retroactive beyond the term in which application for resident classification is made.

e. A student who gives incorrect or misleading information to evade payment of nonresident fees shall be subject to serious disciplinary action and must also pay the nonresident fees for each term previously attended.

f. Review committee. These regulations shall be administered by the registrar or someone designated by the registrar. The decision of the registrar or designated person may be appealed to a university review committee. The decision of the review committee may be appealed to the state board of regents.

1.4(2) Guidelines.

a. The following general guidelines are used in determining the resident classification of a student for admission, tuition, and fee purposes:

(1) A financially dependent student whose parents move from Iowa after the student is enrolled remains a resident provided the student maintains continuous enrollment. A financially dependent student whose parents move from Iowa during the senior year of high school will be considered a resident provided the student has not established domicile in another state.

(2) In deciding why a person is in the state of Iowa, the person's domicile will be considered. A person who comes to Iowa from another state and enrolls in any institution of postsecondary education for a full program or substantially a full program shall be presumed to have come to Iowa primarily for educational reasons rather than to establish a domicile in Iowa.

(3) A student who was a former resident of Iowa may continue to be considered a resident provided absence from the state was for a period of less than 12 months and provided domicile is reestablished. If the absence from the state is for a period exceeding 12 months, a student may be considered a resident if evidence can be presented showing that the student has long-term ties to Iowa and reestablishes an Iowa domicile.

A person or the dependent of a person whose domicile is permanently established in Iowa, who has been classified as a resident for admission, tuition, and fee purposes, may continue to be classified as a resident so long as domicile is maintained, even though circumstances may require extended absence of the person from the state. It is required that a person who claims Iowa domicile while living in another state or country will provide proof of the continual Iowa domicile as evidence that the person:

1. Has not acquired a domicile in another state,
2. Has maintained a continuous voting record in Iowa, and
3. Has filed regular Iowa resident income tax returns during absence from the state.

(4) A student who moves to Iowa may be eligible for resident classification at the next registration following 12 consecutive months in the state provided the student is not enrolled as more than a half-time student (6 credits for an undergraduate or professional student, 5 credits for a graduate student) in any academic year term, is not enrolled for more than 4 credits in a summer term for any classification, and provides sufficient evidence of the establishment of an Iowa domicile.

(5) A student who has been a continuous student and whose parents move to Iowa may become a resident at the beginning of the next term provided the student is dependent upon the parents for a majority of financial assistance.

(6) A person who has been certified as a refugee or granted asylum by the appropriate agency of the United States who enrolls as a student at a university governed by the Iowa state board of regents may be accorded immediate resident status for admission, tuition, and fee purposes when the person:

1. Comes directly to the state of Iowa from a refugee facility or port of debarkation, or
2. Comes to the state of Iowa within a reasonable time and has not established domicile in another state.

Any refugee or individual granted asylum not meeting these standards will be presumed to be a nonresident for admission, tuition, and fee purposes and thus subject to the usual method of proof of establishment of Iowa residency.

(7) An alien who has immigrant status establishes Iowa residency in the same manner as a United States citizen.

(8) At the regent institutions, American Indians who have origins in any of the original people of North America and who maintain a cultural identification through tribal affiliation or community recognition with one or more of the tribes or nations connected historically with the present state of Iowa, including the Iowa, Kickapoo, Menominee, Miami, Missouri, Ojibwa (Chippewa), Omaha, Otoe, Ottawa (Odawa), Potawatomi, Sac and Fox (Sauk, Meskwaki), Sioux, and Winnebago (Ho Chunk), will be assessed Iowa resident tuition and fees.

b. Additional guidelines are used in determining the resident classification of a veteran, qualified military person, and children and spouses of a veteran or qualified military person for purposes of admission and undergraduate, graduate, or professional tuition and mandatory fees:

(1) A person who is stationed on active duty at the Rock Island arsenal as a result of military orders, or the child or spouse/domestic partner of such person, is entitled to resident status for purposes of undergraduate, graduate, or professional tuition and mandatory fees. The child or spouse/domestic partner may be required to submit appropriate documentation to the university.

(2) A veteran who is eligible for benefits or has exhausted benefits under any federal program authorizing veteran educational benefits is entitled to resident status for purposes of undergraduate, graduate, or professional tuition and mandatory fees. The child or spouse/domestic partner of a veteran who meets these requirements is entitled to resident status for undergraduate, graduate, or professional tuition. The child or spouse/domestic partner may be required to submit appropriate documentation to the university.

(3) A person who is moved into the state as the result of military or civil orders from the government for other than educational purposes, or the child or spouse/domestic partner of such a person, is entitled to resident status. The child or spouse/domestic partner may be required to submit appropriate documentation to the university. Legislation, effective July 1, 1977, requires that military personnel who claim residency in Iowa (home of record) will be required to file Iowa resident income tax returns.

1.4(3) Facts.

a. The following circumstances, although not necessarily conclusive, have probative value in support of a claim for resident classification:

(1) Reside in Iowa for 12 consecutive months, and be primarily engaged in activities other than those of a full-time student, immediately prior to the beginning of the term for which resident classification is sought.

(2) Reliance upon Iowa resources for financial support.

(3) Domicile in Iowa of persons legally responsible for the student.

(4) Former domicile in the state and maintenance of significant connections therein while absent.

(5) Acceptance of an offer of permanent employment in Iowa.

(6) Military orders, if for other than educational purposes.

(7) Other facts indicating the student's domicile will be considered by the universities in classifying the student.

b. The following circumstances, standing alone, do not constitute sufficient evidence of domicile to effect classification of a student as a resident under these regulations:

(1) Voting or registration for voting.

(2) Employment in any position normally filled by a student.

(3) The lease of living quarters.

(4) Admission to a licensed practicing profession in Iowa.

(5) Automobile registration.

(6) Public records, for example, birth and marriage records, Iowa driver's license.

(7) Continuous presence in Iowa during periods when not enrolled in school.

(8) Ownership of property in Iowa, or the payment of Iowa taxes.

This rule is intended to implement Iowa Code section 262.9(3).

[ARC 7911B, IAB 7/1/09, effective 7/1/09; ARC 1991C, IAB 5/13/15, effective 6/17/15]

681—1.5(262) Registration and transcripts—general. A person may not be permitted to register for a course or courses at a state board of regents institution until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

A state board of regents institution may withhold official transcripts of the academic record of a person until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

This rule is intended to implement Iowa Code section 262.9.

681—1.6(262) College-bound program.

1.6(1) Definitions.

“Accredited private institution” means an institution of higher education as defined in Iowa Code section 261.9, subsection 5.

“Commission” means the college aid commission.

“Financial need” means the difference between the student’s financial resources, including resources available from the student’s parents and the student, as determined by a completed parents’ financial statement and including any non-campus-administered federal or state grants and scholarships, and the student’s estimated expenses while attending the institution. A student shall accept all available federal and state grants and scholarships before being considered eligible for grants under the Iowa minority academic grants for economic success program. Financial need shall be reconsidered on at least an annual basis.

“Full-time student” means an individual who is enrolled at an accredited private institution or board of regents university for at least 12 semester hours or the trimester or quarter equivalent.

“Minority person” means an individual who is black, Hispanic, Asian, or a Pacific Islander, American Indian, or an Alaskan Native American.

“Part-time student” means an individual who is enrolled at an accredited private institution or board of regents university in a course of study including at least three semester hours or the trimester or quarter equivalent of three semester hours.

“Program” means the Iowa minority academic grants for economic success program established in this division.

1.6(2) Policy on college-bound program.

a. The regent institutions will cooperate with other state and local agencies, including the department of education, the college aid commission, and educational institutions in implementing the college-bound program.

b. The universities will develop programs for elementary, middle and secondary school students and their families in the following areas:

- (1) Encouragement to consider attending a postsecondary institution;
- (2) Enrichment and academic preparation;
- (3) Information about how to apply for admission.

c. College-bound program vouchers will be awarded to students on the basis of the participation of the student and the student’s family in the college-bound program. One voucher will be awarded for participation in each college-bound program sponsored by a university.

(1) Each university will maintain records concerning those students who participate in the college-bound program, according to its established policies and procedures. The records will include information on those students who have received college-bound program vouchers which are described in Iowa Code section 262.92(2). The University of Iowa will maintain a central record on all students who have received college-bound program vouchers on behalf of all regent institutions and will make appropriate information available to the college aid commission.

(2) College-bound program vouchers may be used by students enrolled at a regent institution or at a private college or university in Iowa.

(3) A student holding vouchers and enrolling at a regent institution will receive priority in the award of funds under the Iowa minority academic grants for economic success (IMAGES) program. Awards under the IMAGES program are made on the basis of financial need. A student may be eligible for an additional award from the institution in which the student is enrolled.

(4) A student holding vouchers and enrolling at a private college or university in Iowa will receive priority in the award of funds under the Iowa minority academic grants for economic success program as provided by the rules of the college aid commission.

(5) The presidents, or their designees, will administer and coordinate the college-bound program at the universities. As part of the coordination, they will establish liaison with the appropriate state and local agencies, serve as the university contact and promote collaborative efforts among the regent universities and other appropriate agencies and institutions. Annual reports to the board of regents shall be prepared by each regent university. The reports shall contain relevant information as to the accomplishments of the program in the past year and a plan of action with goals and objectives for the forthcoming year. Reports shall be submitted to the board of regents on October 1 of each year.

This rule is intended to implement Iowa Code section 262.92.

681—1.7(262) Application fees. Application fees required for admission to the University of Iowa, Iowa State University and the University of Northern Iowa are as follows:

University of Iowa

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$85
Graduate/professional domestic student	\$60
Graduate/professional international student	\$100
PharmD student	\$100
Reentry fee	\$20

Iowa State University

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$50
Graduate/professional domestic student	\$60
Graduate/professional international student	\$100
Veterinary Medicine	\$75

University of Northern Iowa

Undergraduate domestic student and nondegree student	\$40
Undergraduate international student	\$50
Graduate/professional domestic student	\$60
Graduate/professional international student	\$75
Reentry fee	\$20

This rule is intended to implement Iowa Code section 262.9(3).

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 4
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761—4.1(22,305) General provisions.

4.1(1) Scope of chapter.

a. This chapter describes the provisions governing public access to records that are owned by or in the physical possession of the department. However, access to personnel and payroll records may also be subject to the rules of the department of administrative services.

b. This chapter does not affect the policy of the department to respond, without charge, to routine oral or written inquiries that do not involve the furnishing of records.

c. This chapter does not make available records compiled by the department in reasonable anticipation of court litigation or formal administrative proceedings. The availability of these records to the public or to any individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the department.

4.1(2) Custodian. The custodian of a record is the person who heads the departmental office responsible for that record. The department's electronic Records Management Manual identifies the offices that are responsible for particular records.

a. As used in this chapter, the term "custodian" includes the custodian's superiors and the custodian's designees.

b. A custodian's designee may include but is not limited to the records center.

c. The custodian of a record is authorized to provide or deny access to that record in accordance with the provisions of this chapter. However, the custodian's authority to provide access to a confidential record is limited to the persons listed in subrule 4.4(2).

4.1(3) Address of records center. The address of the department's records center is: Records Management Section, Information Technology Division, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

4.1(4) Records Management Manual.

a. The department's electronic Records Management Manual contains the records management information required by Iowa Code chapter 305, including descriptions of department records and their formats, management, maintenance, storage, retention, security, and disposal.

b. The manual also contains the descriptive information on records that is required by Iowa Code section 22.11. The manual is updated as needed and its provisions are made a part of these rules.

c. The manual is available for examination and copying at the department's records center and at various other departmental offices located throughout the state. A copy of the manual may also be obtained, upon request, from the records center.

4.1(5) Availability of open records. Open records of the department are available to the public for examination and copying unless otherwise provided by state or federal law, regulation or rule.

4.1(6) Data processing matching. All departmental data processing systems that have common data elements can potentially match, collate and compare personally identifiable information.

4.1(7) Warranty. No warranty of the accuracy or completeness of a record is made.

4.1(8) Existing records. A request for access shall apply only to records that exist at the time the request is made and access is provided. The department is not required to create, compile or procure a record solely for the purpose of making it available. EXCEPTIONS: See Iowa Code section 22.3A and subrule 4.4(4).

4.1(9) Definitions. As used in this chapter:

"Confidential record" means a record that is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7 or another provision of law, but that may be disclosed upon order of the court, the custodian of the record, or by another person duly authorized

to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

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

“Personally identifiable information” means information about an individual in a record that identifies the individual and is retrievable by a unique personal identifier associated with the individual.

“Public” means those persons who are not officials, employees or agents of the department.

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

“Requester” means a member of the public.

This rule is intended to implement Iowa Code chapter 22 and section 305.15.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 2049C, IAB 7/8/15, effective 8/12/15]

761—4.2(22) Statement of policy and purpose. It is the policy of the department that free and open examination of public records is generally in the public interest. The purpose of these rules is to facilitate broad public access to open records and sound determinations with respect to the handling of confidential records.

This rule is intended to implement Iowa Code chapter 22.

761—4.3(22) Access to records.

4.3(1) Submission of request for access.

a. A request for access to a record shall be submitted to the custodian of the record. If the requester does not know the identity of the custodian, the request may be submitted to the records center at the address in subrule 4.1(3). The records center will forward the request to the custodian.

b. Notwithstanding paragraph “a” of this subrule, any request that may be related to a potential or an actual tort claim or other litigation shall be submitted to the following address: General Counsel, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. If the custodian receives a request of this nature, the custodian shall forward the request to the department’s general counsel.

c. If a request for access is misdirected, department personnel will forward the request to the custodian.

4.3(2) Office hours. Open records are available during customary office hours, which are 8 a.m. to 4:30 p.m., excluding Saturdays, Sundays, and legal holidays.

4.3(3) Form of request. A request for access to a record shall reasonably describe the record requested. A request for access to an open record may be made orally or in writing. A requester shall not be required to give reasons for requesting an open record.

4.3(4) Response to request. The custodian shall provide access to an open record promptly upon request. However, if the size or nature of the request makes prompt access infeasible, the custodian shall fill the request as soon as feasible and give the requester an estimate of when the record will be available.

4.3(5) Delay. Access to a record may be delayed for one of the purposes authorized by Iowa Code subsection 22.8(4) or 22.10(4). The custodian shall inform the requester of the reason for the delay and the estimated length of the delay.

4.3(6) Security of records. No person may, without permission from the custodian, search agency files or remove any record from the place where it is made available. The custodian shall supervise the examination and copying of records and protect the records from damage and disorganization. Original paper records shall be released from department custody only upon court order. At least one certified copy shall be retained in the file if the original record is released.

4.3(7) Copies. A photocopy of an open record may be made on department photocopiers. If a photocopier is not available in the office where an open record is kept, the custodian shall permit its examination in that office and, if requested, arrange to have a copy made elsewhere. Most department records are stored in electronic formats; therefore, if the requested record is electronic, an electronic copy will be provided. If the requester is unable to open and read an electronic copy, or if the record does not exist in electronic form, a hard copy will be provided.

4.3(8) Fees. The department may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service, whether electronic or hard copy, shall not exceed the cost of providing the service.

This rule is intended to implement Iowa Code sections 22.2, 22.3, 22.4, 22.8, 22.10, and 22.11.
[ARC 2049C, IAB 7/8/15, effective 8/12/15]

761—4.4(22) Access to confidential records. The following provisions are in addition to those specified in rule 761—4.3(22) and are minimum requirements. A statute or another department rule may impose additional requirements for access to certain classes of confidential records. A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The department shall not refuse to release the nonconfidential information simply because of the manner in which the record is compiled or stored.

4.4(1) Procedure.

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

- (1) Submit the request in writing.
- (2) Provide proof of identity and authority to secure access to the record.
- (3) Sign a certified statement or affidavit listing the specific reasons justifying access to the record and provide any proof necessary to establish relevant facts.

b. Response to request. The custodian shall notify the requester of approval or denial of the request for access. If the requester indicates to the custodian that a written notice is desired if the request for access is denied, the custodian shall provide such notice promptly. The notice shall be signed by the custodian and include:

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

c. Reconsideration of denial. A requester whose request is denied by the custodian may apply to the director of transportation for reconsideration of the request.

4.4(2) Release of confidential records by the custodian. The custodian may release a confidential record or a portion of it:

- a.* To the legislative services agency pursuant to Iowa Code section 2A.3.
- b.* To the citizens' aide pursuant to Iowa Code section 2C.9.
- c.* To other governmental officials and employees only as needed to discharge their duties.
- d.* To those persons as permitted or required by rule 761—4.9(22).
- e.* To persons authorized by the subject of the record in accordance with rule 761—4.5(22).
- f.* To the public information board pursuant to Iowa Code section 23.6.

4.4(3) Release of confidential records by the director.

a. The director of transportation may release a confidential record or a portion of it to a person not covered in subrule 4.4(2) if the release:

- (1) Is permitted by statute, rule or another provision of law, and
- (2) Is not inconsistent with the stated or implied purpose of the law which establishes or authorizes confidentiality.

b. Before the director of transportation releases a record to a person not covered in subrule 4.4(2), the director of transportation may notify the subject of the record of the impending release and may give the subject a reasonable amount of time to seek an injunction.

4.4(4) Information released. If a person is provided access to less than an entire record, the department shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released or a copy of the record from which the information not to be released has been deleted.

This rule is intended to implement Iowa Code section 22.11.
[ARC 2049C, IAB 7/8/15, effective 8/12/15]

761—4.5(22) Consent to release a confidential record to a third party. To the extent permitted by law, the subject of a confidential record may consent to its release to a third party. The consent must be in writing and must identify the particular record that may be disclosed and the particular person or class of persons to whom the record may be disclosed. The subject of the record may be required to provide proof of identity. Appearance of counsel before the agency on behalf of a person who is the subject of a confidential record may be deemed to constitute consent for the department to disclose records about that person to the person's counsel.

This rule is intended to implement Iowa Code section 22.11.

761—4.6(22) Requests for confidential treatment.

4.6(1) A person may request that all or a portion of a record be confidential. The request must be submitted in writing to the custodian and:

- a. Identify the information for which confidential treatment is sought.
- b. Cite the legal basis that justifies confidential treatment.
- c. Demonstrate that disclosure of the information would clearly not be in the public interest.
- d. Give the reasons why any person or persons would be substantially and irreparably injured by disclosure of the information. The requester may be required to provide any proof necessary to support these reasons.

4.6(2) The custodian shall notify the requester in writing of the granting or denial of the request and, if denied, the reasons therefor.

4.6(3) If the request is denied, the requester may apply to the director of transportation for reconsideration of the request.

This rule is intended to implement Iowa Code sections 22.8 and 22.11.
[ARC 2049C, IAB 7/8/15, effective 8/12/15]

761—4.7(22) Procedure by which additions, dissents, or objections may be entered into records. Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the custodian. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any agency proceeding.

This rule is intended to implement Iowa Code section 22.11.

761—4.8(22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department shall notify the person of the use that will be made of the information, which persons outside the agency might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these or other rules of the department, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, orally, or by other appropriate means.

This rule is intended to implement Iowa Code section 22.11.

761—4.9(22) Confidential records. This rule describes the types of departmental information or records that are confidential. This rule is not exhaustive. A citation of the legal authority for confidentiality follows each description. The following records shall be kept confidential. Records are listed by category, according to the legal basis for withholding them from public inspection.

Descriptions:

4.9(1) Records which are exempt from disclosure under Iowa Code section 22.7.

4.9(2) Records which constitute attorney work product, attorney-client communications, or are otherwise privileged. (Attorney work product is confidential under Iowa Code sections 22.7, 622.10 and 622.11, Iowa R. C. P. 1.503, Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications

are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Iowa Rules of Professional Conduct, and case law.)

4.9(3) Those portions of the department's staff manuals, instructions or other statements issued by the department which set forth criteria or guidelines to be used by its departmental staff in auditing, making inspections, settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when the disclosure of such statements would enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the department. (Iowa Code sections 17A.2 and 17A.3)

4.9(4) The detailed minutes and recordings of closed sessions of the commission. However, if a closed session regards a real estate purchase or sale, the minutes and recording shall be available for public inspection when the transaction discussed is completed. (Iowa Code section 21.5)

4.9(5) Vehicle accident reports submitted to the department by drivers and peace officers. (Iowa Code sections 321.266 and 321.271)

a. However, access shall be granted to those persons authorized by Iowa Code section 321.271.

b. Reserved.

4.9(6) Unless otherwise ordered by the court, all information filed with the court for the purpose of securing a warrant for an arrest including, but not limited to, a citation and affidavits, until such time as a peace officer has made the arrest and has made the officer's return on the warrant, or the defendant has made an initial appearance in court. (Iowa Code section 804.29)

a. However, the information in the record may be disseminated without court order during the course of official duties to the persons authorized in Iowa Code section 804.29.

b. Reserved.

4.9(7) All information filed with the court for the purpose of securing a warrant for a search, including, but not limited to, an application and affidavits, until such time as a peace officer has executed the warrant and has made return thereon. (Iowa Code section 808.13)

a. During the period of time that information is confidential, it shall be sealed by the court, and the information contained therein shall not be disseminated to any person other than a peace officer, magistrate or other court employee, in the course of official duties.

b. Reserved.

4.9(8) Information obtained by the department from the examining of reports, returns or records required to be filed or kept under the provisions of Iowa Code chapter 452A, except where disclosure is authorized by Iowa Code chapter 452A. (Iowa Code section 452A.63)

4.9(9) Sealed bids, until the time set for the public opening of bids, whereupon bids are unsealed and no longer confidential. (Iowa Code section 72.3)

4.9(10) Those records which, if disclosed, would diminish competition or would give an improper advantage to persons who are in an adverse position to the department. These records shall be kept confidential until the transaction to which they relate is consummated. However, if disclosure would reveal information which would hinder future competition, the records shall be kept confidential. (Iowa Code sections 17A.2, 17A.3, 22.7 and 313.10, Iowa Code chapter 553, and 761—Chapter 20)

a. Examples of records which could, in the proper circumstances, be determined to be within this category include, but are not limited to:

(1) Detailed estimates of the cost of a proposed contract.

(2) Economic analyses for determining pavement types.

(3) Negotiations for a proposed contract.

(4) Methodology for determining unfair bidding practices or bid rigging.

(5) Price quotations solicited.

(6) The value of points assigned to a bid rating formula prior to the time set for public opening of bids.

(7) Laboratory testing reports of suppliers' products. These may also be trade secrets. The subject of the report has the right of access to it.

b. Reserved.

4.9(11) Audit reviews for determining equal employment opportunity contract compliance. (Iowa Code section 22.7 and 5 U.S.C. §§ 552 and 552a)

a. The subject of the audit review has the right of access to it.

b. Reserved.

4.9(12) All financial records and any information contained within them that are made available to the department, unless otherwise expressly permitted to be divulged by federal or state law. (Iowa Code sections 22.7 and 422.20 and 5 U.S.C. §§ 552 and 552a)

4.9(13) Personal information in any motor vehicle record, including personal information contained on electronic driver's license or nonoperator's identification card records that is provided by the licensee or card holder to the department for use by law enforcement, first responders, emergency medical service providers, and other medical personnel responding to or assisting with an emergency. (Iowa Code sections 22.7 and 321.11 and 18 U.S.C. § 2721 et seq.)

a. Information other than personal information contained on electronic driver's license or nonoperator's identification card records that is provided by the licensee or card holder to the department for use by law enforcement, first responders, emergency medical service providers, and other medical personnel responding to or assisting with an emergency may be disclosed only as provided in Iowa Code sections 321.11 and 321.11A, 18 U.S.C. § 2721 et seq., and 761—Chapters 415, 610 and 611.

b. The subject of the personal information has the right of access to the information.

4.9(14) A report received by the department from a physician licensed under Iowa Code chapter 148, an advanced registered nurse practitioner licensed under Iowa Code chapter 152 and licensed with the board of nursing, a physician assistant licensed under Iowa Code chapter 148C or an optometrist licensed under Iowa Code chapter 154 regarding a person who has been diagnosed as having a physical or mental condition which would render the person physically or mentally incompetent to operate a motor vehicle in a safe manner. (Iowa Code section 321.186)

4.9(15) Certain records regarding undercover driver's licenses issued to peace officers, as specified in 761—Chapter 625. (Iowa Code sections 22.7 and 321.189A)

a. The subject of the record and the head of the law enforcement agency employing the subject have the right of access to the record.

b. Reserved.

4.9(16) Records related to confidential plates issued for government vehicles. (Iowa Code section 321.19)

a. The head of the agency to which the vehicle is assigned has the right of access to the record.

b. Reserved.

4.9(17) Certified transcripts of labor payrolls (also known as certified payroll records) filed by contractors for federal-aid construction contracts, in accordance with the following paragraphs. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a, and 42 U.S.C. § 405)

a. The social security numbers in a certified payroll record are confidential. The record itself may be confidential if its release would give advantage to competitors and serve no public purpose.

b. The prime contractor and subcontractor, if applicable, that filed the record have the right of access to it.

c. Certified payroll records shall be released to the U.S. Department of Labor and Federal Highway Administration during investigations.

d. The custodian may release a certified payroll record with social security numbers withheld to representatives of the Iowa Labor Management Work Preservation Fund.

e. The custodian may release a certified payroll record with social security numbers withheld to persons outside the department other than the persons listed in paragraphs 4.9(17) "b" to "d" according to the following procedure:

(1) The request for the record must be in writing.

(2) The custodian shall send a copy of the request by registered mail to the prime contractor. If the request is for subcontractor information, the custodian shall send copies of the request to both the subcontractor and prime contractor.

(3) The requested record shall not be released until 14 calendar days have expired from receipt of the request by the contractor(s) to give the contractor(s) an opportunity to seek an injunction.

4.9(18) Information concerning an open or pending railroad accident investigation conducted on behalf of or in conjunction with the Federal Railroad Administration or National Transportation Safety Board to the extent necessary to prevent denial of funds, services or essential information from the United States government. (Iowa Code section 22.9)

4.9(19) A geographic computer database, except upon terms and conditions acceptable to the department. (Iowa Code section 22.2)

4.9(20) Confidential information, as defined in Iowa Code section 86.45, filed with the workers' compensation commissioner. (Iowa Code section 22.7)

4.9(21) An intelligence assessment and intelligence data under Iowa Code chapter 692, except where disclosure is required or authorized by the Iowa Code. (Iowa Code chapter 692 and Iowa Code section 22.7)

4.9(22) Information in a record that would permit the commission, subject to Iowa Code chapter 21, to hold a closed session pursuant to Iowa Code section 21.5 in order to avoid public disclosure of that information, until such time as final action is taken on the subject matter of that information or unless otherwise authorized by the Iowa Code. (Iowa Code section 22.7)

4.9(23) All other information or records that by law are or may be confidential.

This rule is intended to implement Iowa Code chapters 22, 553 and 692; Iowa Code sections 17A.2, 17A.3, 21.5, 72.3, 313.10, 321.11, 321.11A, 321.19, 321.186, 321.189A, 321.266, 321.271, 422.20, 452A.63, 622.10, 622.11, 804.29 and 808.13; 5 U.S.C. §§ 552 and 552a; 18 U.S.C. § 2721 et seq.; and 42 U.S.C. § 405.

[ARC 2049C, IAB 7/8/15, effective 8/12/15]

761—4.10(22) Release of confidential records. Rescinded IAB 1/8/03, effective 2/12/03.

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