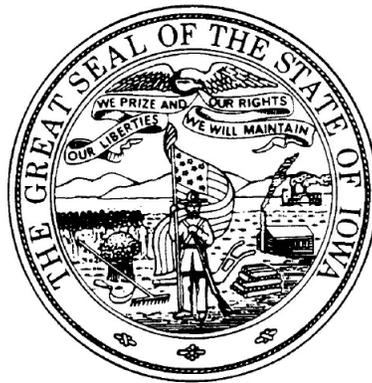


State of Iowa

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Supplement

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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

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Replace Chapter 23

Real Estate Appraiser Examining Board[193F]

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Educational Examiners Board[282]

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Credit Union Department[295] renamed Credit Union Division[189] under the Department of Commerce by 1986 Iowa Acts, Senate File 2175, section 751, effective July 1, 1986. See IAB 9/10/86.

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CHAPTER 23
UNIFORM WAIVER RULES

189—23.1(17A,ExecOrd11) Scope of chapter. This chapter outlines a uniform process for the granting of waivers from rules adopted by the board or the superintendent in situations where no other more specifically applicable law provides for waivers. The intent of this chapter is to allow persons to seek exceptions to the application of rules issued by the board or the superintendent. This chapter shall not apply to rules that merely define the meaning of a statute or other provision of law or precedent if the division does not possess delegated authority to bind the courts to any extent with its definition. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

23.1(1) Definitions.

“*Board*” means the credit union review board created by Iowa Code section 533.107.

“*Person*” means an individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any legal entity.

“*Superintendent*” means the superintendent of credit unions appointed by the governor to direct and regulate credit unions pursuant to Iowa Code chapter 533.

“*Waiver*” means an agency action which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

23.1(2) Applicability.

a. The superintendent may grant a waiver from a rule adopted by the board or superintendent only if (1) the board or superintendent has jurisdiction over the rule; (2) no statute or rule otherwise controls the granting of a waiver from the rule from which waiver is requested; and (3) the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law.

b. No waiver may be granted from a requirement which is imposed by statute.
[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.2(17A,ExecOrd11) Superintendent discretion. The decision on whether the circumstances justify the granting of a waiver shall be made at the discretion of the superintendent upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the superintendent based on the unique, individual circumstances set out in the petition.

23.2(1) Criteria for waiver. The superintendent may, in response to a completed petition, grant a waiver from a rule, in whole or in part, as applied to the circumstances of a specified situation if the superintendent finds all of the following:

a. The application of the rule would result in an undue hardship on the person for whom the waiver is requested;

b. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

c. The provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

In determining whether a waiver should be granted, the superintendent shall consider the public interest, policies and legislative intent of the statute on which the rule is based. When the rule from which a waiver is sought establishes administrative deadlines, the superintendent shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

23.2(2) Special waiver rules not precluded. These uniform waiver rules shall not preclude the superintendent from granting waivers in other contexts including, without limitation, those described in Iowa Code sections 533.303 and 533.401 or on the basis of other standards if a statute or other rule authorizes the superintendent to do so and the superintendent deems it appropriate to do so.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.3(17A,ExecOrd11) Requester's responsibilities in filing a waiver petition.

23.3(1) Application. All petitions for waiver must be submitted in writing to the Credit Union Division, 200 East Grand Avenue, Suite 370, Des Moines, Iowa 50309. If the petition relates to a pending contested case, a copy of the petition shall also be filed in the contested case proceeding.

23.3(2) Content of petition. A petition for waiver shall include the following information where applicable and known to the requester (for an example of a petition for waiver, see Exhibit A at the end of this chapter):

- a. A description and citation of the specific rule from which a waiver is requested.
- b. The specific waiver requested, including the precise scope and operative period that the waiver will extend.
- c. The relevant facts that the petitioner believes would justify a waiver under each of the four criteria specified in subrule 23.2(1).
- d. A signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify a waiver.
- e. A history of any prior contacts between the superintendent and the petitioner relating to the regulated activity, license, grant, loan or other financial assistance affected by the proposed waiver, including a description of each affected license, grant, loan or other financial assistance held by the requester, any notices of violation, contested case hearings, or investigative or examination reports relating to the regulated activity, license, grant or loan within the past five years.
- f. Any information known to the requester regarding the treatment of similar cases by the superintendent.
- g. The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the granting of a waiver.
- h. The name, address, and telephone number of any person or entity that would be adversely affected by the granting of a petition.
- i. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.
- j. Signed releases of information authorizing persons with knowledge regarding the request to furnish the superintendent with information relevant to the waiver.

23.3(3) Burden of persuasion. When a petition is filed for a waiver from a rule, the burden of persuasion shall be on the petitioner to demonstrate by clear and convincing evidence that the superintendent should exercise the superintendent's discretion to grant the petitioner a waiver.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.4(17A,ExecOrd11) Notice. The superintendent shall acknowledge a petition upon receipt. The superintendent shall ensure that, within 30 days of the receipt of the petition, notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law. In addition, the superintendent may give notice to other persons. To accomplish this notice provision, the superintendent may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and provide a written statement to the superintendent attesting that notice has been provided.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.5(17A,ExecOrd11) Superintendent's responsibilities regarding petition for waiver.

23.5(1) Additional information. Prior to issuing an order granting or denying a waiver, the superintendent may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the superintendent may, on the superintendent's own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the superintendent or the superintendent's designee.

23.5(2) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply in three situations: (a) to any petition for a waiver of rule filed within a contested case; (b) when the board or superintendent so provides by rule or order; or (c) when a statute so requires.

23.5(3) Ruling. An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and operative period of the waiver if one is issued.

23.5(4) Conditions. The superintendent may place any condition on a waiver that the board or superintendent finds desirable to protect the public health, safety, and welfare.

23.5(5) Narrowly tailored exception. A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

23.5(6) Time period of waiver. A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the superintendent a waiver may be renewed if the superintendent finds that grounds for a waiver continue to exist.

23.5(7) Time for ruling. The superintendent shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the superintendent shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

23.5(8) When deemed denied. Failure of the superintendent to grant or deny a petition within the required time period shall be deemed a denial of that petition by the superintendent.

23.5(9) Service of order. Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.6(17A,ExecOrd11) Public availability. All orders granting or denying waivers under this chapter shall be indexed, filed and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the superintendent is authorized or required to keep confidential. The superintendent may accordingly redact confidential information from petitions or orders prior to public inspection.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.7(17A,ExecOrd11) Voiding or cancellation. A waiver is void if the material facts upon which the request or petition is based are not true or if material facts have been withheld. A waiver issued by the superintendent pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and opportunity for hearing, the superintendent issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order has been demonstrated to be insufficient; or

3. The subject of the waiver order has failed to comply with any conditions contained in the order.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.8(17A,ExecOrd11) Violations. Violation of conditions in the waiver order is the equivalent of violation of the particular rule for which the waiver is granted and is subject to the same remedies or penalties.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.9(17A,ExecOrd11) Defense. After the superintendent issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.10(17A,ExecOrd11) Appeals. Granting or denying a request for waiver is final agency action under Iowa Code chapter 17A. An appeal to district court shall be taken within 30 days of the issuance of the order in response to the request unless a contrary time is provided by rule or statute. [ARC 5784C, IAB 7/28/21, effective 9/1/21]

189—23.11(17A,ExecOrd11) Submission of waiver information. Within 60 days of granting or denying a waiver, the superintendent shall make a submission on the Internet site established pursuant to Iowa Code section 17A.9A for the submission of waiver information. The submission shall identify the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the superintendent’s actions on waiver requests. If practicable, the report shall detail the extent to which granting a waiver has established a precedent for additional waivers and the extent to which the granting of a waiver has affected the general applicability of the rule itself.

Exhibit A

Sample Petition (Request) for Waiver

BEFORE THE SUPERINTENDENT OF CREDIT UNIONS

Petition by (insert name of petitioner) for the waiver of (insert rule citation) relating to (insert the subject matter).



PETITION FOR WAIVER

A request for waiver from a rule adopted by the superintendent shall include the following information in the petition for waiver where applicable and known:

- a. Provide the petitioner’s (person asking for a waiver) name, address, and telephone number.
- b. Describe and cite the specific rule from which a waiver is requested.
- c. Describe the specific waiver requested; include the exact scope and operative time period that the waiver will extend.
- d. Explain the important facts that the petitioner believes justify a waiver. Include in your answer (1) why applying the rule will result in undue hardship on the petitioner; and (2) how granting the waiver will not prejudice the substantial legal rights of any person; and (3) that the provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and (4) where applicable, how substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.
- e. Provide a history of prior contacts between the superintendent and petitioner relating to the regulated activity, license, grant, loan or other financial assistance that would be affected by the waiver; include a description of each affected license, grant, loan or other financial assistance held by the petitioner, any notices of violation, contested case hearings, or investigative or examination reports relating to the regulated activity, license, grant or loan within the past five years.
- f. Provide information known to the petitioner regarding the treatment by the superintendent of similar cases.
- g. Provide the name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the granting of a waiver.
- h. Provide the name, address, and telephone number of any person or entity that would be adversely affected or disadvantaged by the granting of the waiver.
- i. Provide the name, address, and telephone number of any person with knowledge of the relevant or important facts relating to the requested waiver.
- j. Provide signed releases of information authorizing persons with knowledge regarding the request to furnish the superintendent with information relevant to the waiver.

I hereby attest to the accuracy and truthfulness of the above information.

Petitioner's signature

Date

Petitioner should note the following when requesting or petitioning for a waiver:

1. The petitioner has the burden of proving to the superintendent, by clear and convincing evidence, the following: (a) application of the rule to the petitioner would result in an undue hardship on the petitioner; and (b) waiver in the specific case would not prejudice the substantial legal rights of any person; and (c) the provisions of the rule subject to the petition for waiver are not specifically mandated by statute or another provision of law; and (d) where applicable, how substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

2. The superintendent may request additional information from or request an informal meeting with the petitioner prior to issuing a ruling granting or denying a request for waiver.

3. All petitions for waiver must be submitted in writing to the Credit Union Division, 200 East Grand Avenue, Suite 370, Des Moines, Iowa 50309. If the petition relates to a pending contested case, a copy of the petition shall also be filed in the contested case proceeding.

[ARC 5784C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Executive Order Number 11 and Iowa Code section 17A.9A.

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REAL ESTATE APPRAISER EXAMINING BOARD[193F]

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CHAPTER 1
ORGANIZATION AND ADMINISTRATION

[Prior to 2/20/02, see 193F—Chapters 2, 9 and 11]

193F—1.1(543D) Description.

1.1(1) The purpose of the real estate appraiser examining board is to administer and enforce the provisions of Iowa Code chapter 543D (Iowa Voluntary Appraisal Standards and Appraiser Certification Law of 1989) with regard to the appraisal of real property in the state of Iowa, including the examination of candidates and issuance of certificates and registrations; investigation of alleged violations and infractions of the appraisal standards and appraiser certification law; and the disciplining of appraisers. The importance of the role of the appraiser places ethical and professional standards on those who serve in this capacity. To this end, the board has promulgated these rules and has adopted the Uniform Standards of Professional Appraisal Practice (USPAP) to clarify the board's intent and procedures and to promote and maintain a high level of public trust in professional appraisal practice.

1.1(2) All official communications, including submissions and requests, should be addressed to the board at its official address, 200 E. Grand Avenue, Suite 350, Des Moines, Iowa 50309.

1.1(3) All board action under Iowa Code chapter 543D and 193F—Chapter 17 shall be taken under the supervision of the superintendent, as provided in Iowa Code section 543D.23 and the implementing rules set forth herein.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 2808C, IAB 11/9/16, effective 1/1/17; ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—1.2(543D) Administrative authority.

1.2(1) The superintendent is vested with authority to review, approve, modify, or reject all board action pursuant to Iowa Code chapter 543D and 193F—Chapter 17. The superintendent may exercise all authority conferred upon the board and shall have access to all records and information to which the board has access. In supervising the board, the superintendent shall independently evaluate the substantive merits of recommended or proposed board actions which may be anticompetitive.

1.2(2) In performing its duties and in exercising its authority under Iowa Code chapter 543D and 193F—Chapter 17, the board may take action without preclearance by the superintendent if the action is ministerial or nondiscretionary. As used in this chapter, “ministerial or nondiscretionary” shall include any action expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. The board may, for example, grant or deny an application for initial or reciprocal certification as a real estate appraiser, an application for registration as an associate real estate appraiser, or an application for a temporary practice permit by an out-of-state appraiser, on any ground expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee.

1.2(3) Prior to taking discretionary action under Iowa Code chapter 543D and 193F—Chapter 17, the board shall secure approval of the superintendent if the proposed action is or may be anticompetitive, as provided in 193F—Chapter 17. As used in this chapter, “discretionary” shall include any action that is authorized but not expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. Examples of discretionary action include orders in response to petitions for rule making, declaratory orders, or waivers from rules, rule making, disciplinary proceedings against licensees, administrative proceedings against unlicensed persons, or any action commenced in the district court.

1.2(4) Determining whether any particular action is or may be anticompetitive is necessarily a fact-based inquiry dependent on a number of factors, including potential impact on the market or restraint of trade. With respect to disciplinary actions, for instance, a proceeding against a single licensee for violating appraisal standards would not have an impact on the broader market and would accordingly not be an anticompetitive action. Commencement of disciplinary proceedings which affect all or a substantial subset of appraisers may have a significant market impact. When in doubt as to whether a proposed discretionary action is or may be anticompetitive, the board may submit the proposed action through the preclearance procedures outlined in 193F—Chapter 17.

1.2(5) A person aggrieved by any final action of the board taken under Iowa Code chapter 543D or 193F—Chapter 17 may appeal that action to the superintendent within 20 days of the date the board issues the action.

a. The appeal process applies whether the board action at issue was ministerial or nondiscretionary, or discretionary, and whether the proposed action was or was not submitted through a preclearance process before the superintendent.

b. No person aggrieved by a final action of the board may seek judicial review of that action without first appealing the action to the superintendent, as more fully described in 193F—Chapter 17.

c. Records, filings, and requests for public information. Final board action, regardless of whether such board action is ministerial, nondiscretionary, or discretionary, shall be immediately effective when issued by the board but is subject to review or appeal to the superintendent as permitted by and in accordance with 193F—Chapter 17. If a timely review is initiated or a timely appeal is taken, the effectiveness of such final board action shall be delayed during the pendency of such review or appeal. [ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 2808C, IAB 11/9/16, effective 1/1/17; ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—1.3(543D) Annual meeting. The annual meeting of the board shall be the first meeting scheduled after April 30. At this time, the chairperson and vice chairperson shall be elected to serve until their successors are elected.

[ARC 1467C, IAB 5/28/14, effective 7/2/14]

193F—1.4(543D) Other meetings. In addition to the annual meeting, and in addition to other meetings, the time and place of which may be fixed by resolution of the board, any meeting may be called by the chairperson of the board or by joint call of a majority of its members.

[ARC 1467C, IAB 5/28/14, effective 7/2/14]

193F—1.5(543D) Executive officer's duties.

1.5(1) The executive officer shall cause complete records to be kept of applications for examination and registration, certificates and permits granted, and all necessary information in regard thereto.

1.5(2) The executive officer shall determine when the legal requirements for certification and registration have been satisfied with regard to issuance of certificates or registrations, and the executive officer shall submit to the board any questionable application.

1.5(3) The executive officer shall keep accurate minutes of the meetings of the board. The executive officer shall keep a list of the names of persons issued certificates as certified general real property appraisers, certified residential real property appraisers and associate real property appraisers.

193F—1.6(543D) Records, filings, and requests for public information. Unless otherwise specified by the rules of the department of commerce, the board is the principal custodian of its own agency orders, statements of law or policy issued by the board, legal documents, and other public documents on file with the board.

1.6(1) Any person may examine public records promulgated or maintained by the board at its office during regular business hours as specified in 193F—Chapter 25.

1.6(2) Records, documents and other information may be gathered, stored, and available in electronic format. Information, various forms, documents, and the law and rules may be reviewed or obtained anytime by the public from the board's Internet website located at idob.state.ia.us/reap.

1.6(3) Deadlines. Unless the context requires otherwise, any deadline for filing a document shall be extended to the next working day when the deadline falls on a Saturday, Sunday, or official state holiday. [ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—1.7(543D) Adoption, amendment or repeal of administrative rules.

1.7(1) The board shall adopt, amend or repeal its administrative rules in accordance with the provisions of Iowa Code section 17A.4. Prior to the adoption, amendment or repeal of any rule of the board, any interested person, as described in Iowa Code section 17A.4(1)“b,” may submit any data, views, or arguments in writing concerning such rule or may request to make an oral presentation

concerning such rule. Such written comments or requests to make oral presentations shall be filed with the board at its official address and shall clearly state:

a. The name, address, and telephone number of the person or agency authoring the comment or request;

b. The number and title of the proposed rule, which is the subject of the comment or request as given in the Notice of Intended Action;

c. The general content of the oral presentation. A separate comment or request to make an oral presentation shall be made for each proposed rule to which remarks are to be asserted.

1.7(2) The receipt and acceptance for consideration of written comments and requests to make oral presentations shall be acknowledged by the board.

1.7(3) Written comments received after the deadline set forth in the Notice of Intended Action may be accepted by the board although their consideration is not assured. Requests to make an oral presentation received after the deadline shall not be accepted and shall be returned to the requester.

193F—1.8(22) Public records and fair information practices. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.9(68B) Sales of goods and services. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.10(17A) Petitions for rule making. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.11(17A) Declaratory orders. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.12(252J,261) Denial of issuance or renewal of license for nonpayment of child support or student loan. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.13(17A) Waivers and variances. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.14(543D,17A,272C) Investigations and investigatory subpoenas. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.15(543D,17A,272C) Contested case procedures. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.16(272C) Impaired licensees. Rescinded **ARC 4379C**, IAB 3/27/19, effective 5/1/19.

193F—1.17(543D) Types of appraiser classifications. There are three types of appraiser classifications:

1. Associate real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 4.

2. Certified residential real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 5.

3. Certified general real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 6.

[**ARC 7774B**, IAB 5/20/09, effective 6/24/09]

193F—1.18(543D) Qualified state appraiser certifying agency.

1.18(1) The real estate appraiser examining board is a state appraiser certifying agency in compliance with Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). As a result, persons who are issued certificates by the board to practice as certified real estate appraisers are authorized under federal law to perform appraisal services for federally related transactions and are identified as such in the National Registry maintained by the Appraisal Subcommittee (ASC).

1.18(2) The board must adhere to the criteria established by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation when registering associate appraisers or certifying certified appraisers under Iowa Code chapter 543D.

[ARC 1467C, IAB 5/28/14, effective 7/2/14]

193F—1.19(543D) May 1, 2018, criteria.

1.19(1) Effective on and after May 1, 2018, the AQB has changed the criteria for eligibility for certification as a certified appraiser. No person may be certified as a certified appraiser on or after May 1, 2018, unless the person is eligible under the most recent criteria.

1.19(2) The May 1, 2018, criteria were adopted by the AQB in 2018 and have been widely disseminated, including on the board's website at: idob.state.ia.us/reap/. The May 1, 2018, criteria modify the conditions under which applicants for certification are eligible to take the required examinations.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4169C, IAB 12/5/18, effective 1/9/19]

193F—1.20(543D) Application and work product deadlines.

1.20(1) *Summary of registration requirements for registration as an associate.* The associate appraiser and supervisory appraiser provisions are more fully set out in 193F—Chapters 4 and 15, respectively. Before submitting an application for registration with the board, a person seeking registration as an associate appraiser must complete 75 hours of appraisal education and secure a qualified supervisory appraiser. An associate appraiser applicant who submits an application to the board office must have completed all required qualifying education and the supervisory appraiser/associate coursework prior to submitting an application for registration.

1.20(2) *Summary of certification requirements.* As more fully set out in 193F—Chapters 3, 5, and 6, a person who is in the process of completing the education, experience, and examination required for certification as a certified appraiser may not submit an application for certification to the board until all prerequisites have been satisfactorily completed. The prerequisites include the following: qualifying college and core criteria appraiser education, qualifying examination, 1,500 hours of qualifying experience in a minimum of 12 months for residential appraisers or 3,000 hours of qualifying experience in a minimum of 18 months for general appraisers, and work product review. Work product review requires numerous steps, as provided in 193F—5.6(543D) and 193F—6.6(543D). The work product review process includes the applicant's submission of a work product experience log to the board; the board's selection of three appraisals to review; communication of the selected appraisals to the applicant; the applicant's submission of the three appraisals and associated work files to the board in electronic and paper formats; review of the appraisals and work files by a reviewer retained by the board; the reviewer's submission of review reports to the board; a meeting between the applicant, the applicant's supervisor, and the board's work product review committee; a formal board vote at a board meeting; and communication of approval, denial, or deferral to the applicant. All of these steps must be completed before an applicant with approved work product can submit an application for certification to the board office. If the applicant's supervisor is unable to attend the work product review meeting, the applicant, or the applicant's supervisor, must submit the circumstances surrounding the absence to the executive officer so that it may be determined if the work product review meeting should be rescheduled.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 4707C, IAB 10/9/19, effective 11/13/19; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—1.21(543D) National criminal history check. All applicants for any of the classifications listed in 193F—1.17(543D), including an applicant seeking to upgrade from a certified residential credential to a certified general credential, must satisfactorily complete a state and national criminal history check as a condition of registration as an associate real property appraiser, certification as a residential, or certification as or upgrade to a general real property appraiser. The applicant shall authorize release of the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may

perform a new state and national criminal history check or may reject and return the application to the applicant.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 3084C, IAB 5/24/17, effective 6/28/17; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—1.22(272C,543D) Process for board review of eligibility.

As more fully set forth in, as described in, and in accordance with 193F—Chapter 13, before applying for registration as an associate appraiser or certification as a certified appraiser, a person with a criminal history that may impair registration or certification may request that the board evaluate the prospective applicant's criminal history.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—1.23(272C,543D) Applications. Unless otherwise provided by rule of the board, abandoned applications shall be deemed withdrawn. An application is abandoned if the applicant has not accessed or modified the application through the board's electronic licensing database within the preceding six months, or when approved by the board but the applicant has failed to pay any required fees within 30 calendar days of the date approved by the board. For purposes of this rule, "application" means any request, application, registration, or petition submitted to the board through the licensing database, including but not limited to the following:

1. Add supervisor appraiser;
2. Associate appraiser registration;
3. Conversion application;
4. Course application;
5. Course instructor application;
6. Course provider application;
7. Examination and experience application;
8. Formal wall certificate request;
9. Pre-/post-course approval request;
10. Reactivation application;
11. Reciprocity application;
12. Reinstatement application;
13. Removal of associate from supervisor;
14. Removal of supervisor from associate;
15. Renewal application;
16. Temporary practice permit application;
17. General application to apply military service to an experience or educational requirement for licensure;
18. Background packet request;
19. Petition for waiver from administrative rules;
20. Request for change of legal name;
21. Request for verification (license and/or examination history); or
22. Request to change license address.

[ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code sections 543D.4, 543D.5, 543D.7, 543D.17, 543D.20 and 543D.22 and chapter 272C.

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CHAPTER 3
GENERAL PROVISIONS FOR EXAMINATIONS

193F—3.1(543D) Types of appraiser certificates. Rescinded IAB 5/20/09, effective 6/24/09.

193F—3.2(543D) Examinations. Examinations for certified residential real property appraisers and certified general real property appraisers shall be AQB-endorsed and administered by the board or its authorized representative as often as the board deems necessary, but not less than one time per year. Successful completion of the examination is valid for a period of 24 months.

3.2(1) Disclosure of confidential information. Members of the board shall not disclose a final examination score to any person other than the person who took the examination. Persons who take the examination may consent to the publication of their names on a list of passing candidates.

Other information relating to the examination results, including the specific grades by subject matter, shall be given only to the person who took the examination, except that the board may:

a. Disclose the specific grades by subject matter to the regulatory authority of any other state or foreign country in connection with the candidate's application for a reciprocal certificate or license from the other state or foreign country, but only if requested by the candidate.

b. Disclose the specific grades by subject matter to educational institutions, professional organizations, or others who have a legitimate interest in the information provided in conjunction with the scores.

3.2(2) The board shall enter into a contractual relationship with a qualified testing service to develop and administer AQB-approved examinations and shall maintain control over the examination process.

3.2(3) and 3.2(4) Rescinded IAB 5/20/09, effective 6/24/09.

3.2(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months of passing the examination, that examination result loses its validity to support the issuance of an appraiser credential. To regain eligibility for the credential, the applicant must retake and pass the examination. This requirement applies to individuals obtaining an initial certified credential or upgrading to the certified general classification.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—3.3(543D) Conduct of applicant.

3.3(1) Any individual who subverts or attempts to subvert the examination process may, at the discretion of the board, have the individual's examination scores declared invalid for the purpose of certification in Iowa, be barred from the appraisal certification examinations in Iowa, or be subject to the imposition of other sanctions that the board deems appropriate.

3.3(2) Conduct that subverts or attempts to subvert the examination process includes, but is not limited to:

a. Conduct that violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the examination; aiding by any means in the reproduction or reconstruction of any portion of the examination; selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered examination.

b. Conduct that violates the standard of test administration, such as communicating with any other examination candidate during the administration of the examination; copying answers from another candidate or permitting one's answers to be copied by another candidate during the examination; referencing any books, notes, written or printed materials or data of any kind, other than the examination materials distributed.

c. Conduct that violates the examination process, such as falsifying or misrepresenting educational credentials or other information required for admission to the examination; impersonating an examination candidate or having an impersonator take the examination on one's behalf.

3.3(3) Any examination candidate who challenges a decision of the board under this rule may request a contested case hearing pursuant to rule 193F—20.39(546,543D,272C). The request for hearing shall

be in writing, shall briefly describe the basis for the challenge, and shall be filed in the board's office within 30 days of the date of the board decision that is being challenged.

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—3.4(543D) Application for certification or registration. Applicants for certification or registration must successfully complete the appropriate examination.

3.4(1) All initial applications for certification or associate registration shall be made on forms provided by the board. The board may deny an application as described in Iowa Code sections 543D.12 and 543D.17. Specific examples of grounds for denial include knowingly making a false statement, submitting false information, refusing to provide complete information in response to a question in an application for certification, or participating in any form of fraud or misrepresentation; the revocation of another professional license; or, subject to the limitations and processes set forth in Iowa Code section 272C.15 and corresponding implementing rules located at 193F—Chapter 13, a conviction, including a conviction based upon a plea of guilty or nolo contendere, of a crime which is substantially related to the qualifications, functions and duties of a person developing real estate appraisals and communicating real estate appraisals to others. The board may also deny an application based on disciplinary action pending or taken against an applicant consistent with Iowa Code section 272C.12.

3.4(2) A certificate or associate registration shall contain the applicant's name, appraiser classification, Iowa certificate number and the signature of the board chairperson.

3.4(3) An initial certificate shall not be issued until the applicant has demonstrated compliance with all required appraiser qualifications for certification, which include examination, core criteria, collegiate education, and real property appraiser experience pursuant to Iowa Code section 543D.9 and 193F—Chapter 5 or 6.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5484C, IAB 2/24/21, effective 3/31/21; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—3.5(543D) Work product review. Rescinded IAB 5/20/09, effective 6/24/09.

These rules are intended to implement Iowa Code section 543D.8.

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CHAPTER 4
ASSOCIATE REAL PROPERTY APPRAISER
[Prior to 2/20/02, see rule 193F—3.6(543D)]

193F—4.1(543D) Qualifications to register as an associate appraiser.**4.1(1) Education.**

a. A person applying for registration as an associate appraiser shall, at a minimum, satisfactorily complete all AQB-approved, qualifying education courses required under the current AQB criteria specifying educational standards applicable for registration as an associate residential appraiser or associate general appraiser. Each required course must be completed before the person can obtain an associate credential.

b. The initial qualifying education must be completed no more than five years prior to the date of application. Credit toward all or part of the core criteria qualifying education requirements in this rule may also be obtained via the completion of a degree in real estate from an accredited degree-granting college or university, provided that the college or university has had its curriculum reviewed and approved by the AQB and so long as the degree was granted no more than five years prior to the date of application.

4.1(2) Training. Prior to registration as an associate, a person must complete a course that complies with the specifications for course content established by the AQB specifically oriented to the requirements and responsibilities of supervisory appraisers and associate appraisers. The course must be completed before the person can obtain an associate credential. This course cannot be applied toward the required hours of qualifying or continuing education.

4.1(3) Background check. A state and national criminal history check shall be performed on any new associate appraiser. The applicant shall authorize release of the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may perform a new state and national criminal history check or may reject and return the application to the applicant.

4.1(4) Supervision. An applicant must obtain the services of a certified appraiser who meets the supervisor qualification criteria in rule 193F—15.3(543D).

4.1(5) Application form. After completing the education, training, background check, and obtainment of a supervisor outlined in subrules 4.1(1) to 4.1(4), a person applying for registration as an associate appraiser shall apply for registration. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:

- a.* Be on a form and in the manner prescribed by the board;
- b.* Be signed by the applicant and supervisor(s), be certified as accurate, or display an electronic signature by the applicant and supervisor(s) if submitted electronically;
- c.* Be fully completed;
- d.* Reflect, on its face, full compliance with all applicable qualifying education requirements including the supervisory appraiser/trainee appraiser course;
- e.* Be accompanied by the fee as identified in 193F—Chapter 12.

4.1(6) Registration denial. The board may deny an application for registration as an associate appraiser on any ground identified in 193F—subrule 3.4(1) or on any ground upon which the board may impose discipline against an associate appraiser, as provided in 193F—Chapter 7.

[ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 3084C, IAB 5/24/17, effective 6/28/17; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5484C, IAB 2/24/21, effective 3/31/21; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—4.2(543D) Supervision of associate appraisers.

4.2(1) Direct supervision. An associate appraiser is subject to the direct supervision of a certified real property appraiser. Qualifications for a supervisory appraiser are outlined in 193F—Chapter 15. An associate appraiser may be supervised by more than one supervisory appraiser.

4.2(2) Supervisor registration. An associate appraiser shall identify all supervisors by whom the associate will be supervised on forms provided by the board and shall promptly notify the board in the

event of an addition of a, or change in, supervisor or if the associate will no longer be supervised by a previously identified supervisor. An associate appraiser who does not have at least one approved active supervisor meeting the requirements of 193F—Chapter 15 will be placed in inactive status until such time as the associate finds a supervisor meeting the requirements of 193F—Chapter 15. Associate appraisers wishing to maintain an inactive license must continue to renew on a biennial basis in accordance with rule 193F—4.3(543D).

4.2(3) *Scope of practice.* The scope of practice of an associate appraiser is the same as the scope of practice of the supervisory appraiser. An associate appraiser supervised by a certified residential appraiser shall accordingly be restricted to the scope of practice of a certified residential appraiser, while an associate appraiser supervised by a certified general appraiser shall be subject to the same scope of practice as a certified general appraiser.

4.2(4) *Logs.* An associate appraiser shall maintain an appraisal experience log that includes all information required by the AQB and the board as a precondition for certification and shall maintain the log contemporaneously with the performance of supervised real property appraisal services. Every log page shall have the names and signatures of the associate appraiser and supervisory appraiser, the state certification number of the supervisory appraiser, and the date of signatures. Required log entries shall, at a minimum, include the following for each appraisal:

- a. Type of property;
- b. Date of report;
- c. Complete address of appraised property or full legal description;
- d. A specific description of work performed by the associate appraiser, scope of review, and supervision of the supervisory appraiser;
- e. Number of actual work hours by the associate on the assignment; and
- f. The approach(es) to value utilized in the report.

4.2(5) *Monitoring of logs.* The associate appraiser shall have the appraisal log reviewed and signed by the supervisory appraiser at least monthly. Upon written request by the board, the associate appraiser and the supervisory appraiser shall submit a copy of the associate appraiser's log by letter or email within ten calendar days. The failure of an associate appraiser or supervisory appraiser to submit the requested log is a ground for disciplinary action. A separate appraisal log shall be maintained for each supervisory appraiser.

[ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—4.3(543D) Renewal of associate appraiser registration. An associate appraiser registration must be renewed on a biennial basis as more fully described in 193F—Chapter 9. An associate appraiser is subject to the same continuing education requirements as are applicable to a certified appraiser as a precondition for renewal. Continuing education requirements are outlined in 193F—Chapter 11.

193F—4.4(543D) Progress toward certification as a certified residential appraiser or certified general appraiser.

4.4(1) *Associate classification.* The associate appraiser classification is intended for those persons training to become certified appraisers and is not intended as a long-term method of performing appraisal services under the supervision of a certified appraiser in the absence of progress toward certification. As a result, the board may impose deadlines for achieving certification, or for satisfying certain prerequisites toward certification, for those persons who apply to renew an associate appraiser registration more than two times. Deadlines, if any, would be imposed as a condition for the third or subsequent renewal.

4.4(2) *Factors to consider.*

a. The board may consider the following noninclusive list of factors when deciding whether to impose a deadline for achieving certification:

- (1) An associate appraiser's access to the educational courses required for certification;
- (2) Whether the associate appraiser had completed the college requirement for certification in advance of registering as an associate appraiser or whether college coursework is in progress;

(3) The associate appraiser's access to supervisory appraisers, the volume of the supervisory appraiser's practice, and the type of certification the associate is training to achieve; and

(4) Such additional factors as may be relevant to the board's determination as to whether the associate appraiser is making good-faith progress toward certification.

b. While the board's policy is to work with associate appraisers and their supervisors in a cooperative manner, an associate appraiser who does not demonstrate good-faith progress toward certification shall be subject to the imposition of deadlines as described in subrule 4.4(1).

4.4(3) Progress reports. In order to assess an associate appraiser's progress toward certification, the board may request periodic progress reports from the associate appraiser and from the associate appraiser's supervisory appraiser or appraisers. Progress reports on the steps an associate appraiser has taken toward certification and the associate appraiser's plans for completing certification prerequisites shall be submitted to the board within ten calendar days of the board's written request. The failure of an associate appraiser or supervisory appraiser to submit the requested progress report is a ground for disciplinary action.

[ARC 1731C, IAB 11/12/14, effective 12/17/14]

193F—4.5(543D) Applying for certification as a certified residential appraiser or certified general appraiser. An associate appraiser may apply for certification as a certified residential real property appraiser by satisfying the requirements of 193F—Chapter 5, or as a certified general real property appraiser by satisfying the requirements of 193F—Chapter 6. The requirements for each type of certification include education, examination, and experience, which includes work product review.

[ARC 7774B, IAB 5/20/09, effective 6/24/09]

193F—4.6(272C,543D) Reinstating or reactivating an associate registration.

4.6(1) In order to reinstate or reactivate an associate registration that has lapsed or been placed in inactive or retired status, the applicant must complete all continuing education required for reinstatement pursuant to 193F—subrule 11.2(5). For purposes of this rule, in addition to the most recent edition of a seven-hour USPAP course, the board shall allow for continuing education only those courses that have been AQB-approved as qualifying education required for certification, as outlined in rules 193F—5.2(543D) and 193F—6.2(543D). The purpose of this requirement is to ensure that those associates reinstating a lapsed, retired, or inactive registration are progressing toward certification. Any qualifying education course taken under this rule as continuing education shall also apply as qualifying education toward certification. If the applicant has completed all qualifying education prior to applying to reinstate a lapsed, retired, or inactive associate registration, the applicant may use any approved continuing education course as provided in 193F—Chapter 11, in addition to the required seven-hour USPAP update course, toward the continuing education required for reinstatement.

4.6(2) If an appraiser's registration is placed in inactive status as a result of the appraiser's failure to maintain at least one approved active supervisor meeting the requirements of 193F—Chapter 15 pursuant to subrule 4.2(2), the applicant must complete the continuing education required by subrule 4.6(1) in order to reinstate the associate registration but is not required to pay any fee that would otherwise be required in connection with such reinstatement so long as the associate has not renewed the registration to inactive status or allowed the registration to lapse prior to reinstating or reactivating the registration.

[ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

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CHAPTER 5
CERTIFIED RESIDENTIAL REAL PROPERTY APPRAISER

[Prior to 2/20/02, see rule 193F—3.4(543D) and 193F—Chapter 4]

193F—5.1(543D) General.

5.1(1) The certified residential real property appraiser classification qualifies the appraiser to appraise one- to four-unit residential properties without regard to value or complexity. The classification includes the appraisal of vacant or unimproved land that is utilized for one- to four-unit residential properties or for which the highest and best use is for one- to four-unit residential properties. The classification does not include the appraisal of subdivisions for which a development analysis/appraisal is necessary.

5.1(2) Certification is composed of three parts: education, examination, and experience, which includes work product review.

5.1(3) All certified residential real property appraisers must comply with USPAP.
[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14]

193F—5.2(543D) Education. Education requirements for an applicant to obtain a certificate as a certified residential real property appraiser shall be in compliance with the criteria as set forth by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation. If an accredited college or university (accredited by the Commission on Colleges, by a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education) accepts the College-Level Examination Program© (CLEP) examination(s) and issues a transcript for the examination(s) showing the college's or university's approval, the CLEP credit will be considered as credit for the college course.

5.2(1) Collegiate education. There are five options toward certification as a certified residential real property appraiser. An applicant must meet at least one of the five options identified in paragraphs 5.2(1) "a" through 5.2(1) "e," below, in order to be eligible for certification as a residential real property appraiser.

a. An applicant holds a bachelor's degree in any field of study from an accredited college or university.

b. An applicant holds an associate's degree in a field of study from an accredited college, junior college, community college, or university that relates to:

- (1) Business administration;
- (2) Accounting;
- (3) Finance;
- (4) Economics; or
- (5) Real estate.

c. Successful completion of 30 semester hours of college-level courses from an accredited college, junior college, community college, or university that cover each of the following specific areas and hours:

- (1) English composition (3 hours);
- (2) Microeconomics (3 hours);
- (3) Macroeconomics (3 hours);
- (4) Finance (3 hours);
- (5) Algebra, geometry, or higher math (3 hours);
- (6) Statistics (3 hours);
- (7) Computer science (3 hours);
- (8) Business law or real estate law (3 hours);
- (9) Two electives in any of the above topics or in accounting, geography, agriculture, economics, business management, or real estate (3 hours each).

d. Successful completion of at least 30 semester hours of College-Level Examination Program© (CLEP) examinations that cover each of the following specific areas and hours:

- (1) College algebra (3 semester hours);
- (2) College composition (6 semester hours);

- (3) College composition modular (3 semester hours);
- (4) College mathematics (6 semester hours);
- (5) Principles of macroeconomics (3 semester hours);
- (6) Principles of microeconomics (3 semester hours);
- (7) Introductory business law (3 semester hours); and
- (8) Information systems (3 semester hours).

e. Any combination of paragraphs 5.2(1)“*c*” and 5.2(1)“*d*,” above, that ensures coverage of all of the topics and hours identified in paragraph 5.2(1)“*c*.” For purposes of determining whether coverage of the topics and hours identified in paragraph 5.2(1)“*c*” has occurred:

- (1) The college algebra CLEP examination may be considered for satisfying the algebra, geometry, or higher math requirement of paragraph 5.2(1)“*c*.”
- (2) The college composition CLEP examination may be considered for satisfying the English composition requirement of paragraph 5.2(1)“*c*.”
- (3) The college composition modular CLEP examination may be considered for satisfying the English composition requirement of paragraph 5.2(1)“*c*.”
- (4) The college mathematics CLEP examination may be considered for satisfying the algebra, geometry, or higher math requirement of paragraph 5.2(1)“*c*.”
- (5) The principles of macroeconomics CLEP examination may be considered for satisfying the macroeconomics or finance requirement of paragraph 5.2(1)“*c*.”
- (6) The principles of microeconomics CLEP examination may be considered for satisfying the microeconomics or finance requirement of paragraph 5.2(1)“*c*.”
- (7) The introductory business law CLEP examination may be considered for satisfying the business law or real estate law requirement of paragraph 5.2(1)“*c*.”
- (8) The information systems CLEP examination may be considered for satisfying the computer science requirement of paragraph 5.2(1)“*c*.”

5.2(2) Core criteria. In addition to the formal education in subrule 5.2(1), an applicant must complete 200 creditable class hours before taking the AQB-approved examination. All courses must be AQB-approved current core criteria to be considered creditable. The required courses and 200 hours consist of the following:

<i>a.</i>	Basic appraisal principles	30 hours
<i>b.</i>	Basic appraisal procedures	30 hours
<i>c.</i>	The 15-hour USPAP course or equivalent	15 hours
<i>d.</i>	Residential market analysis and highest and best use	15 hours
<i>e.</i>	Residential appraiser site valuation and cost approach	15 hours
<i>f.</i>	Residential sales comparison and income approaches	30 hours
<i>g.</i>	Residential report writing and case studies	15 hours
<i>h.</i>	Statistics, modeling and finance	15 hours
<i>i.</i>	Advanced residential applications and case studies	15 hours
<i>j.</i>	Appraisal subject matter electives	20 hours

5.2(3) Degree program. Credit toward core criteria qualifying education requirements may also be obtained via the completion of a degree in real estate from an accredited degree-granting college or university, provided that the college or university has had its curriculum reviewed and approved by the AQB.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19]

193F—5.3(543D) Examination. The prerequisite for taking the AQB-approved examination is completion of 200 creditable course hours as specified in subrule 5.2(2). The 200 creditable course hours, collegiate education, and all experience must be completed as specified in subrules 5.2(1) and 5.2(2) and rule 193F—5.4(543D) prior to the examination. For 5.2(2)“*c*,” equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP qualifying education shall be awarded only when the class is instructed by at least

one AQB-certified USPAP instructor who holds a state-issued certified residential or certified general appraiser credential in active status and good standing.

5.3(1) In order to qualify to sit for the certified residential real property appraiser examination, the applicant must complete the board's application form and provide copies of documentation of completion of all courses claimed that qualify the applicant to sit for the examination.

a. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:

- (1) Be on a form and in the manner prescribed by the board;
- (2) Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;
- (3) Be fully completed;
- (4) Reflect, on its face, full compliance with all applicable continuing education requirements; and
- (5) Be accompanied by the fee specified in 193F—Chapter 12.

b. The core criteria, collegiate education, and experience must be completed and the documentation submitted to the board at the time of application to sit for the examination.

5.3(2) The board may verify educational credits claimed. Undocumented credits will be sufficient cause to invalidate the examination results pursuant to 193F—paragraph 3.3(2) "c."

5.3(3) Responsibility for documenting the educational credits claimed rests with the applicant.

5.3(4) An applicant must supply the original examination scores when applying for certification. Copies of the scores will not be accepted.

5.3(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months after passing the examination, that examination result loses its validity to support issuance of an appraiser credential. To regain eligibility for the credential, the applicant must retake and pass the examination. This requirement applies to individuals obtaining an initial certified credential or upgrading from an associate credential.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—5.4(543D) Supervised experience required for initial certification. Except as otherwise permitted herein, all experience required for initial certification pursuant to Iowa Code section 543D.9 shall be performed as a registered associate real property appraiser under the direct supervision of a certified residential or general real property appraiser pursuant to the provisions of 193F—Chapter 15.

5.4(1) Acceptable experience. The board will accept as qualifying experience the documented experience attained while the applicant for initial certification was in an educational program recognized by the Appraiser Qualifications Board and Appraisal Subcommittee as providing qualifying experience for initial certification, whether or not the applicant was registered as an associate real property appraiser at the time the educational program was completed. Such programs, if approved by federal authorities, will incorporate direct supervision by a certified real property appraiser and such additional program features as to satisfy the purpose of requiring that qualifying experience be attained by the applicant as an associate real property appraiser.

5.4(2) Exceptions. Applicants for certified residential real property certification in Iowa may utilize experience obtained in the absence of registration as an associate real property appraiser under the following circumstances:

a. Subject to any requirements or limitations established by applicable federal authorities, including the AQB and ASC, or applicable federal law, rule, or policy, hours qualifying for experience in any jurisdiction, including in a bordering state, will be considered qualifying hours for experience in Iowa without board approval or authorization, as long as the applicant is able to establish by clear and convincing evidence all of the following:

(1) A majority of the applicant's total qualifying experience hours are completed in Iowa under the direct supervision of a certified real property appraiser pursuant to the provisions of 193F—Chapter 15.

(2) The qualifying hours obtained in another jurisdiction and claimed as experience hours in Iowa were completed in a jurisdiction under the direct supervision of an active certified real estate appraiser in that jurisdiction as required by the AQB and the jurisdiction's laws, rules, or policies.

(3) The nature of the experience attained in another jurisdiction is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

b. Requests for experience performed in the absence of registration as an associate real property appraiser shall be made on forms prescribed by the board.

(1) The burden shall be on the applicant to establish by clear and convincing evidence all of the following:

1. The experience is qualifying experience under the substantive and documentation standards of the AQB and ASC.

2. Denial of the application would impose an undue hardship on the applicant.

3. The nature of the experience attained is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

4. Approval of the application would foster the board's goal of fair and consistent treatment of applicants.

5. A basis exists beyond the individual control of the applicant to explain why the experience at issue could not have been attained by the applicant as an associate real property appraiser under the direct supervision of a certified real property appraiser.

(2) Among the circumstances the board may consider favorably in ruling on an application for approval of unsupervised experience or experience attained by the applicant in the absence of registration as an associate real property appraiser are:

1. The experience was attained before receiving an associate credential in Iowa in a jurisdiction that, at the time, did not register associate real property appraisers or otherwise offer an associate, trainee or equivalent category of certification.

2. The applicant attained the experience while employed in a county assessor's office engaged in mass appraisals, and the experience would otherwise qualify under applicable federal standards.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—5.5(543D) Demonstration of experience. The experience necessary for certification pursuant to Iowa Code section 543D.9 must meet the requirements of this rule. The objective of the demonstration of experience is to ensure that, before the applicant is issued a certificate, the applicant has obtained sufficient diversified experience to perform an appraisal.

5.5(1) The applicant shall provide to the board an appraisal log that includes all information required by the AQB as a precondition for certification and shall maintain the log contemporaneously with the performance of supervised real property appraisal services. The appraisal log shall, at a minimum, include all information as described in 193F—subrule 4.2(4).

5.5(2) The applicant shall accumulate a total of 1,500 hours of residential appraisal experience in no fewer than 12 months while in active status. While the hours may be cumulative, the 12 months must have elapsed before the applicant can apply to take the examination. Experience claimed must have been performed in compliance with USPAP in which the appraiser demonstrates proficiency in appraisal principles methodology, procedures and reporting conclusions. Acceptable appraisal experience includes, but is not limited to, the following:

- a.* Fee and staff appraisal;
- b.* Ad valorem tax appraisal;
- c.* Review appraisal;
- d.* Appraisal analysis;
- e.* Appraisal consulting;
- f.* Highest and best use analysis;
- g.* Feasibility analysis/study; and
- h.* Mass appraisal.

5.5(3) The types of experience set out in 5.5(2) are intended neither to exclude other sorts of appraisal experience nor to prescribe a specified minimum array of experience. However, an applicant who cannot demonstrate a background of experience of the diversity manifested by this rule shall bear the burden of showing that the applicant's experience is of sufficient quality and diversity to fulfill the objective of the demonstration of experience. A diversity of experience includes, but is not limited to, the following:

- a. Performing all approaches to value (i.e., cost, income, sales);
- b. Various reporting types;
- c. Appropriate use of various forms (e.g., gPAR, 1004) and formats;
- d. Various property types (e.g., vacant land, condominium, manufactured home, and rental);
- e. Various assignments that include varying scopes of work (e.g., as is, as completed or proposed, foreclosure, rural properties, estates, use of extraordinary assumption or hypothetical conditions); and
- f. Diversity in value ranges.

5.5(4) An applicant may be required to appear before the board or its representative to supplement or verify evidence of experience, which shall be in the form of written reports or file memoranda.

5.5(5) The board may require inspection, by the board itself or by its representatives, of documentation relating to an applicant's claimed experience. Such inspection may be made at the board's offices or such other place as the board may designate.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—5.6(543D) Work product review.

5.6(1) An applicant shall submit a complete appraisal log at the time of application for examination and work product review. The board will select three appraisals that demonstrate a diversity of experience and approaches to value over various time frames for work product review and request that the applicant submit, both electronically and on paper, one copy of each report and work file for each of the selected appraisals along with the appropriate form and fee. The work product submission shall not be redacted by the applicant; however, the applicant may request the reports remain confidential as specified in subrule 5.6(2). The fee for work product review of the appraisals is provided in 193F—Chapter 12. The board may select the appraisals at random from the entire log or within certain types of appraisals. The board reserves the right to request one or more additional appraisals if those submitted by the applicant raise issues concerning the applicant's competency or compliance with applicable appraisal standards or the degree to which the submitted appraisals are representative of the applicant's work product. Such additional appraisals may be selected at random from the applicant's log or may be selected specifically to provide an example of the applicant's work product regarding a particular type of appraisal.

5.6(2) The board shall treat all appraisals received as public records unless the applicant notifies the board at the time of submission that a submitted appraisal is subject to the confidentiality provisions of appraisal standards or is otherwise confidential under state or federal law. While applicants are encouraged to submit appraisals actually performed for clients, applicants may submit one or more demonstration appraisals if the appraisals are prepared based on factual information in the same manner as applicable to actual appraisal assignments and are clearly marked as demonstration appraisals. Experience gained for work without a traditional client (i.e., a client hiring an appraiser for a business purpose), for example a demonstration appraisal, cannot exceed 50 percent of the total experience requirement.

5.6(3) An applicant seeking to upgrade to a certified residential real property appraiser shall submit three residential appraisals for review.

5.6(4) The board will submit the appraisals to a peer review consultant for an opinion on the appraiser's compliance with applicable appraisal standards.

5.6(5) The work product review process is not intended as an endorsement of an applicant's work product. No applicant or appraiser shall represent the results of work product review in communications with a client or in marketing to potential clients in a manner which falsely portrays the board's work product review as an endorsement of the appraiser or the appraiser's work product. Failure to comply with this prohibition may be grounds for discipline as a practice harmful or detrimental to the public.

5.6(6) The board views work product review, in part, as an educational process. While the board may deny an application based on an applicant's failure to adhere to appraisal standards or otherwise demonstrate a level of competency upon which the public interest can be protected, the board will attempt to work with applicants deemed in need of assistance to arrive at a mutually agreeable remedial plan. A remedial plan may include additional education, desk review, a mentoring program, or additional precertification experience.

5.6(7) An applicant who is denied certification based on the work product review described in this rule, or on any other ground, shall be entitled to a contested case hearing as provided in rule 193F—20.39(546,543D,272C). Notice of denial shall specify the grounds for denial, which may include any of the work performance-related grounds for discipline against a certified appraiser.

5.6(8) If probable cause exists, the board may open a disciplinary investigation against a certificate holder based on the work product review of an applicant. A potential disciplinary action could arise, for example, if the applicant is a certified residential real property appraiser seeking an upgrade to a certified general real property appraiser, or where the applicant is uncertified and is working under the supervision of a certified real property appraiser who cosigned the appraisal report.

5.6(9) After accumulating a minimum of 500 hours of appraisal experience, an applicant may voluntarily submit work product to the board to be reviewed by a peer reviewer for educational purposes only. A maximum of three reports may be submitted for review during the experience portion of the certification process. Work product submitted for educational purposes only will not result in disciplinary action on either the associate appraiser or the associate appraiser's supervisor so long as the appraisal review does not reveal negligent or egregious errors or omissions. The fee for voluntary submissions of work product for review is provided in 193F—Chapter 12.

5.6(10) The board will retain the appraisals for as long as needed as documentation of the board's actions for the Appraisal Subcommittee or as needed in a pending proceeding involving the work product of the applicant or the applicant's supervisor. When no longer needed for such purposes, the work product may be retained or destroyed at the board's discretion.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 4707C, IAB 10/9/19, effective 11/13/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—5.7(543D) Upgrade to a certified general real property appraiser. To upgrade from a certified residential real property appraiser to a certified general real property appraiser, an applicant must complete the following additional education, examination, supervision, and experience requirements and a state and national criminal history check as provided in Iowa Code section 543D.22. For all intents and purposes, a certified residential appraiser seeking to upgrade to a certified general status will be considered an associate appraiser as it relates to differences between the scope of practice of the two licensure categories, and the upgrade process will generally follow the same registration requirements, supervisory identification and maintenance requirements, and processes and procedures generally applicable to associate appraisers set forth in 193F—Chapter 4.

5.7(1) Education.

a. Collegiate education. Certified residential real property appraisers must satisfy the college-level education requirements as specified in rule 193F—6.2(543D).

b. Core criteria. In addition to the formal education and core criteria educational requirements originally required to obtain a certified residential credential, an applicant must complete the following additional 100 creditable, core criteria class hours before taking the AQB-approved examination. All courses must be AQB-approved under current core criteria to be considered creditable. The required courses and 100 hours consist of the following:

- | | |
|--|----------|
| (1) General appraiser market analysis and highest and best use | 15 hours |
| (2) General appraiser sales comparison approach | 15 hours |
| (3) General appraiser site valuation and cost approach | 15 hours |
| (4) General appraiser income approach | 45 hours |

(5) General appraiser report writing and case studies 10 hours

5.7(2) Examination. An applicant must satisfy the examination requirements as specified in rule 193F—6.3(543D).

5.7(3) Supervision and experience.

a. Experience. An applicant must satisfy all of the experience requirements as specified in rules 193F—6.4(543D) and 193F—6.5(543D). In obtaining and documenting the 3,000 total experience hours required by 193F—subrule 6.5(2), as is the case for initial licensure, such hours must be accumulated in no fewer than 18 months while in active status as, in effect, a registered associate appraiser pursuing an upgrade pursuant to this rule and subject to the supervision of an Iowa-certified appraiser. Notwithstanding the foregoing:

(1) To the extent residential appraisal experience may be counted towards licensure in accordance with 193F—subrule 6.5(2), residential appraisal experience obtained as a certified residential appraiser prior to initiating the upgrade process may be included on the appraisal log and, subject to the work product review process, counted towards the experience-hours requirement for purposes of upgrading from a certified real property appraiser to a certified general real property appraiser; provided that such residential appraisal experience obtained prior to initiating the upgrade process shall not apply toward the 18-month requirement.

(2) Applicants may request that the board approve experience hours performed in the absence of registration as an associate real property appraiser by filing an application for approval on a form provided by the board, which application will be subject to and governed by the same processes and standards set forth in rule 193F—6.4(543D).

b. Supervision. Subject to applicable exceptions, all nonresidential experience obtained and applied toward obtaining a certified general credential as part of the upgrade process shall be performed under the direct supervision of a certified general real property appraiser pursuant to the provisions of 193F—Chapter 15 and shall be subject to the identification, notification, maintenance, approval, scope-of-practice, log, and monitoring requirements set forth in 193F—Chapter 4. Both the applicant and the applicant's supervisor(s) must complete a supervisor/trainee course within the five years prior to the board's receipt of the associate registration application identifying a supervisor with the board or prior to the applicant's obtaining or claiming any experience hours under the supervision of that supervisor.

5.7(4) Work product review. An applicant must satisfy the work product review requirements as specified in rule 193F—6.5(543D).

5.7(5) Background check. A state and national criminal history check shall be performed on any appraiser upgrading to a certified general real property appraiser. The applicant shall authorize release of the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may perform a new state and national criminal history check or may reject and return the application to the applicant.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 3084C, IAB 5/24/17, effective 6/28/17; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

These rules are intended to implement Iowa Code sections 543D.5, 543D.8, and 543D.9.

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CHAPTER 6
 CERTIFIED GENERAL REAL PROPERTY APPRAISER
 [Prior to 2/20/02, see rule 193F—3.3(543D) and 193F—Chapter 4]

193F—6.1(543D) General.

6.1(1) The certified general real property appraiser classification qualifies the appraiser to appraise all types of real property.

6.1(2) All certified general real property appraisers must comply with USPAP.

6.1(3) Certification is composed of three parts: education, examination, and experience, which includes work product review.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14]

193F—6.2(543D) Education. Education requirements for an applicant to obtain a certificate as a certified general real property appraiser shall be in compliance with the criteria as set forth by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation.

6.2(1) Collegiate education. Applicants must hold a bachelor's degree or higher from an accredited college, junior college, community college, or university. If an accredited college or university (accredited by the Commission on Colleges, by a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education) accepts the College-Level Examination Program© (CLEP) examination(s) and issues a transcript for the examination(s) showing the college's or university's approval, the CLEP credit will be considered as credit for the college course. An applicant who submits a master's degree or higher as proof of the applicant's bachelor's degree must include an affidavit or a copy of the bachelor's degree attesting that the bachelor's degree is from an accredited college or university.

6.2(2) Core criteria. In addition to the formal education in 6.2(1), an applicant must complete 300 creditable class hours before taking the AQB-approved examination. All courses must be AQB-approved under current core criteria to be considered creditable. The required courses and 300 hours consist of the following:

a. Basic appraisal principles	30 hours
b. Basic appraisal procedures	30 hours
c. The 15-hour USPAP course or equivalent	15 hours
d. General appraiser market analysis and highest and best use	30 hours
e. General appraiser site valuation and cost approach	30 hours
f. General appraiser sales comparison approach	30 hours
g. General appraiser income approach	60 hours
h. General appraiser report writing and case studies	30 hours
i. Statistics, modeling and finance	15 hours
j. Appraisal subject matter electives	30 hours

6.2(3) Degree program. Credit toward core criteria qualifying education requirements may also be obtained via the completion of a degree in real estate from an accredited degree-granting college or university, provided that the college or university has had its curriculum reviewed and approved by the AQB.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19]

193F—6.3(543D) Examination. The prerequisite for taking the AQB-approved examination is completion of 300 creditable course hours as specified in subrule 6.2(2). The 300 core criteria hours, collegiate education, and all experience must be completed as specified in subrules 6.2(1) and 6.2(2) and rule 193F—6.4(543D) prior to the examination. For 6.2(2) "c," equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP qualifying education shall be awarded only when the class is instructed by at least one AQB-certified USPAP instructor who holds a state-issued certified residential or certified general appraiser credential in active status and good standing.

6.3(1) In order to qualify to sit for the certified general real property appraiser examination, the applicant must complete the board's application form and provide copies of documentation of completion of all courses claimed that qualify the applicant to sit for the examination.

a. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:

(1) Be on a form and in the manner prescribed by the board;

(2) Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;

(3) Be fully completed;

(4) Reflect, on its face, full compliance with all applicable continuing education requirements; and

(5) Be accompanied by the fee specified in 193F—Chapter 12.

b. The core criteria, collegiate education, and experience must be completed and documentation submitted to the board at the time of application to sit for the examination.

6.3(2) The board may verify educational credits claimed. Undocumented credits will be sufficient cause to invalidate the examination results pursuant to 193F—paragraph 3.3(2) “c.”

6.3(3) Responsibility for documenting the educational credits claimed rests with the applicant.

6.3(4) An applicant must supply the original examination scores when applying for certification. Copies of the scores will not be accepted.

6.3(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months after passing the examination, that examination result loses its validity to support issuance of an appraiser credential. To regain eligibility for the credential, the applicant must retake and pass the examination. This requirement applies to individuals obtaining an initial certified credential or upgrading from an associate credential.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—6.4(543D) Supervised experience required for initial certification. Except as otherwise permitted herein, all experience required to obtain certification as a certified general real property appraiser pursuant to Iowa Code section 543D.9 shall be performed under the direct supervision of a certified general real property appraiser pursuant to the provisions of 193F—Chapter 15.

6.4(1) Acceptable experience. The board will accept as qualifying experience the documented experience attained while the applicant for initial certification was in an educational program recognized by the Appraiser Qualifications Board and Appraisal Subcommittee as providing qualifying experience for certification, whether or not the applicant was registered as an associate real property appraiser at the time the educational program was completed. Such programs, if approved by federal authorities, will incorporate direct supervision by a certified real property appraiser and such additional program features as to satisfy the purpose of requiring that qualifying experience be attained by the applicant as a real property appraiser.

6.4(2) Exceptions. Applicants for certified general real property certification in Iowa may utilize experience obtained in the absence of registration as an associate real property appraiser under the following circumstances.

a. Subject to any requirements or limitations established by applicable federal authorities, including the AQB and ASC, or applicable federal law, rule, or policy, hours qualifying for experience in any jurisdiction, including a bordering state, will be considered qualifying hours for experience in Iowa without board approval or authorization, as long as the applicant is able to establish by clear and convincing evidence all of the following:

(1) A majority of the applicant's total qualifying experience hours are completed in Iowa under the direct supervision of a certified real property appraiser pursuant to the provisions of 193F—Chapter 15.

(2) The qualifying hours obtained in the jurisdiction and claimed as experience hours in Iowa were completed in another jurisdiction under the direct supervision of an active certified real estate appraiser in that jurisdiction as required by the AQB and the jurisdiction's laws, rules, or policies.

(3) The nature of the experience attained in another jurisdiction is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct

supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

b. Requests for experience performed in the absence of registration as an associate real property appraiser shall be made on forms prescribed by the board.

(1) The burden shall be on the applicant to establish by clear and convincing evidence all of the following:

1. The experience is qualifying experience under the substantive and documentation standards of the AQB and ASC.

2. Denial of the application would impose an undue hardship on the applicant.

3. The nature of the experience attained is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

4. Approval of the application would foster the board's goal of fair and consistent treatment of applicants.

5. A basis exists beyond the individual control of the applicant to explain why the experience at issue could not have been attained by the applicant under the direct supervision of a certified general real property appraiser.

(2) Among the circumstances the board may consider favorably in ruling on an application for approval of unsupervised experience or experience attained by the applicant in the absence of registration as an associate real property appraiser are:

1. The experience was attained before receiving an associate credential in Iowa in a jurisdiction that, at the time, did not require direct supervision or register associate real property appraisers or otherwise offer a category of certification.

2. The applicant attained the experience while employed in a county assessor's office engaged in mass appraisals, and the experience would otherwise qualify under applicable federal standards.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—6.5(543D) Demonstration of experience. The experience necessary for certification pursuant to Iowa Code section 543D.9 must meet the requirements of this rule. The objective of the demonstration of experience is to ensure that, before the applicant is issued a certificate, the applicant has obtained sufficient diversified experience to perform an appraisal.

6.5(1) The applicant shall provide to the board an appraisal log that includes all information required by the AQB as a precondition for certification and shall maintain the log contemporaneously with the performance of supervised real property appraisal services. The appraisal log shall, at a minimum, include all information as described in 193F—subrule 4.2(4).

6.5(2) The applicant shall accumulate a total of 3,000 hours of appraisal experience in no fewer than 18 months while in active status, of which 1,500 hours must consist of nonresidential appraisal experience. While the hours may be cumulative, the 18 months must have elapsed before an applicant can be certified. Experience claimed must have been performed in compliance with USPAP where the appraiser demonstrates proficiency in appraisal principles methodology, procedures and reporting conclusions. Acceptable appraisal experience includes, but is not limited to, the following:

- a.* Fee and staff appraisal;
- b.* Ad valorem tax appraisal;
- c.* Review appraisal;
- d.* Appraisal analysis;
- e.* Appraisal consulting;
- f.* Highest and best use analysis;
- g.* Feasibility analysis/study; and
- h.* Mass appraisal.

6.5(3) The types of experience set out in 6.5(2) are intended neither to exclude other sorts of appraisal experience nor to prescribe a specified minimum array of experience. However, an applicant who cannot

demonstrate a background of experience of the diversity manifested by this rule shall bear the burden of showing that the applicant's experience is of sufficient quality and diversity to fulfill the objective of the demonstration of experience. A diversity of experience includes, but is not limited to, the following:

- a. Performing all approaches to value (i.e., cost, income, sales);
- b. Various reporting types;
- c. Appropriate use of various forms (e.g., gPAR, 1004) and formats;
- d. Various property types (e.g., vacant land, single-family, multifamily, agricultural, retail, industrial, and special purpose);
- e. Various assignments that include varying scopes of work (e.g., as is, as completed or proposed, foreclosure, rural properties, acreages, estates, eminent domain, use of extraordinary assumption or hypothetical conditions); and
- f. Diversity in value ranges.

6.5(4) An applicant may be required to appear before the board or its representative to supplement or verify evidence of experience, which shall be in the form of written reports or file memoranda.

6.5(5) The board may require inspection, by the board itself or by its representatives, of documentation relating to an applicant's claimed experience. Such inspection may be made at the board's offices or such other place as the board may designate.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—6.6(543D) Work product review.

6.6(1) An applicant shall submit a complete appraisal log at the time of application for examination and work product review. The board will then select three appraisals that demonstrate a diversity of experience and approaches to value over various time frames for work product review and request that the applicant submit, both electronically and on paper, one copy of each report and work file for each of the selected appraisals along with the appropriate form and fee. The work product submission shall not be redacted by the applicant; however, the applicant may request the reports remain confidential as specified in subrule 6.6(2). The fee for work product review of the appraisals is provided in 193F—Chapter 12. The board may select the appraisals at random from the entire log or within certain types of appraisals. The board reserves the right to request one or more additional appraisals if those submitted by the applicant raise issues concerning the applicant's competency or compliance with applicable appraisal standards or the degree to which the submitted appraisals are representative of the applicant's work product. Such additional appraisals may be selected at random from the applicant's log or may be selected specifically to provide an example of the applicant's work product regarding a particular type of appraisal.

6.6(2) The board shall treat all appraisals received as public records unless the applicant notifies the board at the time of submission that a submitted appraisal is subject to the confidentiality provisions of appraisal standards or is otherwise confidential under state or federal law. While applicants are encouraged to submit appraisals actually performed for clients, applicants may submit one or more demonstration appraisals if the appraisals are prepared based on factual information in the same manner as applicable to actual appraisal assignments and are clearly marked as demonstration appraisals. Experience gained for work without a traditional client (i.e., a client hiring an appraiser for a business purpose), for example a demonstration appraisal, cannot exceed 50 percent of the total experience requirement.

6.6(3) An applicant seeking original or upgrade certification as a certified general real property appraiser shall submit one residential appraisal and two nonresidential appraisals for review.

6.6(4) The board will submit the appraisals to a peer review consultant for an opinion on the appraiser's compliance with applicable appraisal standards.

6.6(5) The work product review process is not intended as an endorsement of an applicant's work product. No applicant or appraiser shall represent the results of work product review in communications with a client or in marketing to potential clients in a manner which falsely portrays the board's work

product review as an endorsement of the appraiser or the appraiser's work product. Failure to comply with this prohibition may be grounds for discipline as a practice harmful or detrimental to the public.

6.6(6) The board views work product review, in part, as an educational process. While the board may deny an application based on an applicant's failure to adhere to appraisal standards or otherwise demonstrate a level of competency upon which the public interest can be protected, the board will attempt to work with applicants deemed in need of assistance to arrive at a mutually agreeable remedial plan. A remedial plan may include additional education, desk review, a mentoring program, or additional precertification experience.

6.6(7) An applicant who is denied certification based on the work product review described in this rule, or on any other ground, shall be entitled to a contested case hearing as provided in rule 193F—20.39(546,543D,272C). Notice of denial shall specify the grounds for denial, which may include any of the work performance-related grounds for discipline against a certified appraiser.

6.6(8) If probable cause exists, the board may open a disciplinary investigation against a certificate holder based on the work product review of an applicant. A potential disciplinary action could arise, for example, if the applicant is a certified residential real property appraiser seeking an upgrade to a certified general real property appraiser, or where the applicant is uncertified and is working under the supervision of a certified real property appraiser who cosigned the appraisal report.

6.6(9) After accumulating a minimum of 500 hours of appraisal experience, an applicant may voluntarily submit work product to the board to be reviewed by a peer reviewer for educational purposes only. A maximum of three reports may be submitted for review during the experience portion of the certification process. Work product submitted for educational purposes only will not result in disciplinary action on either the associate appraiser or the associate appraiser's supervisor so long as the appraisal review did not reveal negligent or egregious errors or omissions. The fee for voluntary submissions of work product for review is provided in 193F—Chapter 12.

6.6(10) The board will retain the appraisals for as long as needed as documentation of the board's actions for the Appraisal Subcommittee or as needed in a pending proceeding involving the work product of the applicant or the applicant's supervisor. When no longer needed for such purposes, the work product may be retained or destroyed at the board's discretion.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 4707C, IAB 10/9/19, effective 11/13/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—6.7(543D) Background check. A state and national criminal history check shall be performed on any appraiser upgrading to a new credential. The applicant shall authorize release of the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may perform a new state and national criminal history check or may reject and return the application to the applicant.

[ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 3084C, IAB 5/24/17, effective 6/28/17; ARC 5237C, IAB 10/21/20, effective 11/25/20]

These rules are intended to implement Iowa Code sections 543D.5, 543D.8, 543D.9, and 543D.22.

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CHAPTER 7
DISCIPLINARY ACTIONS AGAINST CERTIFIED AND
ASSOCIATE APPRAISERS

193F—7.1(17A,272C,543D) Disciplinary authority. The board is empowered to administer Iowa Code chapters 17A, 272C, and 543D and related administrative rules for the protection and well-being of those persons who may rely upon registered associate appraisers or certified real property appraisers for the performance of real property appraisal services within this state and for clients in this state. To perform these functions, the board is broadly vested with authority to review and investigate alleged acts or omissions of registered associate appraisers and certified real property appraisers to determine whether disciplinary proceedings are warranted, to initiate and prosecute disciplinary proceedings, to establish standards of professional conduct, and to impose discipline pursuant to Iowa Code sections 17A.13, 272C.3 to 272C.6 and 272C.10, and Iowa Code chapter 543D.

193F—7.2(543D) Standards of practice. The standards of practice governing all real property appraisal activities shall be the Uniform Standards of Professional Appraisal Practice, including Provisions, Rules, Comments, and Statements, as promulgated by the Appraisal Standards Board of the Appraisal Foundation. All registered associate appraisers and certified real property appraisers shall comply with the USPAP edition applicable to each appraisal assignment.

193F—7.3(17A,272C,543D) Grounds for discipline. The board may initiate disciplinary action against a registered associate appraiser or a certified real property appraiser based on any one or more of the following grounds:

7.3(1) *Fraud in procuring a registration or certificate.* Fraud in procuring or attempting to procure a registration or certificate includes an intentional perversion of the truth when making application for an initial, renewal, reciprocal, or temporary registration or certificate to practice in this state, including:

- a. False representation of a material fact, whether by word or by conduct, by false or misleading allegation, or by concealment of that which should have been disclosed;
- b. Attempting to file or filing with the board any false or forged diploma, course certificate, identification, credential, license, registration, certification, examination report, affidavit, or other record;
- c. Failing or refusing to provide complete information in response to a question on an application for initial or renewal registration or certification; or
- d. Otherwise participating in any form of fraud or misrepresentation by act or omission.

7.3(2) *Professional incompetence.* Professional incompetence includes, but is not limited to:

- a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.
- b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.
- c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.
- d. Failure to conform to the minimal standards of acceptable and prevailing practice of registered associate appraisers or certified real property appraisers in this state.
- e. A willful, repeated, or material deviation from USPAP standards, or other act or omission that demonstrates an inability to safely practice in a manner protective of the public's interest, including any violation of USPAP's COMPETENCY RULE.

7.3(3) *Deceptive practices.* Deceptive practices are grounds for discipline, whether or not actual injury is established, and include:

- a. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of real property appraising.
- b. Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a registrant or certificate holder

in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

c. Acceptance of any fee by fraud or misrepresentation, or in violation of Iowa Code section 543D.18(2).

d. Falsification of business records or appraisal logs through false or deceptive representations or omissions.

e. Submission of false or misleading reports or information to the board including information supplied in an audit of continuing education, reports submitted as a condition of probation, or any reports identified in this rule.

f. Making any false or misleading statement in support of an application for registration or certification submitted by another.

g. Knowingly presenting as one's own a certificate or registration, certificate or registration number, or signature of another or of a fictitious registrant or certificate holder, or otherwise falsely impersonating a certified appraiser or registered associate appraiser.

h. Representing oneself as a registered associate appraiser or certified appraiser when one's registration or certificate has been suspended, revoked, surrendered, or placed on inactive or retired status, or has lapsed.

i. Permitting another person to use the registrant's or certificate holder's registration or certificate for any purposes.

j. Fraud in representations as to skill or ability.

k. Misrepresenting a specialized service as an appraisal assignment in violation of Iowa Code section 543D.18(3) or (5).

7.3(4) *Unethical, harmful or detrimental conduct.* Registrants and certificate holders engaging in unethical conduct or practices harmful or detrimental to the public may be disciplined whether or not injury is established. Behaviors and conduct which are unethical, harmful or detrimental to the public may include, but are not limited to, the following actions:

a. A violation of 2007 Iowa Acts, Senate File 137, section 5 (improper influence of an appraisal assignment).

b. Verbal or physical abuse, improper sexual contact, or making suggestive, lewd, lascivious, offensive or improper remarks or advances, if such behavior occurs within the practice of real property appraising or if such behavior otherwise provides a reasonable basis for the board to conclude that such behavior within the practice of real estate appraising would place the public at risk.

c. Engaging in a professional conflict of interest, or otherwise violating the public trust, as provided in Iowa Code section 543D.18(1) as amended by 2007 Iowa Acts, Senate File 137, section 3, and in USPAP's ETHICS RULE.

d. Aiding or abetting any unlawful activity for which a civil penalty can be imposed under 193F—16.2(543D).

7.3(5) *Lack of proper qualifications.*

a. Continuing to practice as a registered associate appraiser or certified real property appraiser without satisfying the continuing education required for registration or certificate renewal.

b. Acting as a supervisor without proper qualification, as provided in 193F—15.3(543D).

c. Habitual intoxication or addiction to the use of drugs, or impairment which adversely affects the registrant's or certificate holder's ability to practice in a safe and competent manner.

d. Any act, conduct, or condition, including lack of education or experience and careless or intentional acts or omissions, that demonstrates a lack of qualifications which are necessary to ensure a high standard of professional care as provided in Iowa Code section 272C.3(2) "b," or that impairs a practitioner's ability to safely and skillfully practice the profession.

e. Failure to meet the minimum qualifications for registration as an associate appraiser or certification as a certified real property appraiser.

f. Practicing outside the scope of a residential certification, or outside the scope of a supervisor's residential certification.

7.3(6) *Negligence by the registrant or certificate holder in the practice of the profession.* Negligence by the registrant or certificate holder in the practice of the profession includes:

a. Failure or refusal without good cause to exercise reasonable diligence in developing an appraisal, preparing an appraisal report, or communicating an appraisal.

b. A failure to exercise due care including negligent delegation of duties to or supervision of associate appraisers, or other employees, agents, or persons, in developing an appraisal, preparing an appraisal report, or communicating an appraisal, whether or not injury results.

c. Neglect of contractual or other duties to a client.

7.3(7) *Professional misconduct.*

a. A violation of any of the standards applicable to the development or communication of real estate appraisals as provided in 193F—7.2(543D).

b. Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of real estate appraising.

c. Engaging in any conduct that subverts or attempts to subvert a board investigation, or failure to fully cooperate with a disciplinary investigation of the registrant or certificate holder or with a disciplinary investigation of persons who are not registrants or certificate holders, including failure to comply with a subpoena issued by the board or to respond to a board inquiry within 30 calendar days of the date of mailing by certified mail of a written communication directed to the registrant's or certificate holder's last address on file at the board office.

d. Revocation, suspension, or other disciplinary action taken by a licensing authority of this state or another state, territory, or country. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, discipline by the board based solely on such action shall be vacated.

e. A violation of Iowa Code section 543D.18 as amended by 2007 Iowa Acts, Senate File 137, section 4 (disclosure of significant real property appraisal assistance), or Iowa Code section 543D.18(6).

f. A violation of 2007 Iowa Acts, Senate File 137, section 6 (restrictions on persons assisting in the development or reporting of a certified appraisal).

g. Failure to retain records as provided in Iowa Code section 543D.19.

h. Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

7.3(8) *Willful or repeated violations.* The willful or repeated violation or disregard of any provision of Iowa Code chapter 272C or 543D, or any administrative rule adopted by the board in the administration or enforcement of such chapters.

7.3(9) *Failure to report.*

a. Failure by a registrant or certificate holder or an applicant for a registration or certificate to report in writing to the board any revocation, suspension, or other disciplinary action taken by a licensing authority, in Iowa or any other jurisdiction, within 30 calendar days of the final action.

b. Failure of a registrant or certificate holder or an applicant for a registration or certificate to report, within 30 calendar days of the action, any voluntary surrender of a professional license to resolve a pending disciplinary investigation or action, in Iowa or any other jurisdiction.

c. Failure to notify the board of a criminal conviction within 30 calendar days of the action, regardless of the jurisdiction where it occurred.

d. Failure to notify the board within 30 calendar days after occurrence of any adverse judgment in a professional or occupational malpractice action, or settlement of any claim involving malpractice, regardless of the jurisdiction where it occurred.

e. Failure to report another registrant or certificate holder to the board for any violation listed in these rules, pursuant to Iowa Code section 272C.9(2), promptly after the registrant or certificate holder becomes aware that a reportable violation has occurred.

f. Failure to report to the board the appraiser's principal place of business and any change in the appraiser's principal place of business within 30 calendar days of such change; or failure to report to the board all other addresses at which the appraiser engages in the business of preparing real estate appraisal reports, or any change in such information, within 30 calendar days of such occurrence or change.

g. Failure of an associate appraiser or supervisor to timely respond to board requests for information, as provided in 193F—Chapter 4.

7.3(10) *Failure to comply with board order.* Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order, or other decision of the board imposing discipline.

7.3(11) *Conviction of a crime.*

a. Conviction, in this state or any other jurisdiction, of any felony offense that directly relates to the profession, or of any crime which is substantially related to the qualifications, functions, duties or practice of a person developing or communicating real estate appraisals to others. Any crime involving deception, dishonesty or disregard for the safety of others shall be deemed directly related to the practice of real property appraising. A certified copy of the final order or judgment of conviction or plea of guilty in this state or in another jurisdiction shall be conclusive evidence of the conviction. "Conviction" shall include any plea of guilty or nolo contendere, including Alford pleas, or finding of guilt whether or not judgment or sentence is deferred, withheld, or not entered, and whether or not the conviction is on appeal. If such conviction is overturned or reversed by a court of last resort, discipline by the board based solely on the conviction shall be vacated. A conviction qualifies as a felony offense if the offense is designated as a felony in the jurisdiction in which the conviction occurred, or if the offense is committed in this state, the offense would be a felony, without regard to its designation elsewhere. An offense directly relates to the profession if either:

(1) The actions taken in furtherance of an offense are actions customarily performed within the scope of practice of the profession, or

(2) The circumstances under which an offense was committed are circumstances customary to the profession.

b. Notwithstanding the foregoing, a conviction may be grounds for revocation or suspension only if an unreasonable risk to public safety exists because the offense directly relates to the duties and responsibilities of the profession.

[ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5484C, IAB 2/24/21, effective 3/31/21; ARC 5785C, IAB 7/28/21, effective 9/1/21]

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CHAPTER 8
INVESTIGATIONS AND DISCIPLINARY PROCEDURES

193F—8.1(272C,543D) Disciplinary action. The real estate appraiser examining board has authority pursuant to Iowa Code chapters 543D, 17A and 272C to impose discipline for violations of these Iowa Code chapters and the rules promulgated thereunder.

193F—8.2(17A,272C,543D) Initiation of disciplinary investigations. The board may initiate a licensee disciplinary investigation upon the board's receipt of information suggesting that a licensee may have violated a law or rule enforced by the board which, if true, would constitute grounds for licensee discipline.

193F—8.3(272C,543D) Sources of information. Without limitation, the following nonexclusive list of information sources may form the basis for the initiation of a disciplinary investigation or proceeding:

1. News articles or other media sources.
2. General or random review of publicly available work product.
3. Reports filed with the board by the commissioner of insurance pursuant to Iowa Code subsection 272C.4(9).
4. Complaints filed with the board by any member of the public.
5. License applications or other documents submitted to the board, including appraisal logs and appraisal reports.
6. Reports to the board from any regulatory or law enforcement agency from any jurisdiction.
7. Board audits of licensee compliance with conditions for licensure, such as continuing education or qualifying experience.

193F—8.4(17A,272C,543D) Conflict of interest. If the subject of a complaint is a member of the board, or if a member of the board has a conflict of interest in any disciplinary matter before the board, that member shall abstain from participation in any consideration of the complaint and from participation in any disciplinary hearing that may result from the complaint.

193F—8.5(272C,543D) Complaints. Written complaints may be submitted to the board office by mail, email, facsimile or personal delivery by members of the public, including clients, business organizations, lenders, governmental bodies, licensees, or other individuals or entities with knowledge of possible law or rule violations by licensees.

8.5(1) Contents of a written complaint. Written complaints may be submitted on forms provided by the board that are available from the board office and on the board's website. Written complaints, whether submitted on a board complaint form or in other written media, shall contain the following information:

- a. The full name, address, and telephone number of the complainant (person complaining).
- b. The full name, address, and telephone number of the respondent (licensee against whom the complaint is filed).
- c. A statement of the facts and circumstances giving rise to the complaint, including a description of the alleged acts or omissions that the complainant believes demonstrate that the respondent has violated or is violating laws or rules enforced by the board.
- d. If known, citations to the laws or rules allegedly violated by the respondent.
- e. Evidentiary supporting documentation.
- f. Steps, if any, taken by the complainant to resolve the dispute with the respondent prior to filing a complaint.

8.5(2) Immunity. As provided by Iowa Code section 272C.8, a person shall not be civilly liable as a result of filing a report or complaint with the board unless such act is done with malice, nor shall an employee be dismissed from employment or discriminated against by an employer for filing such a report or complaint.

8.5(3) Role of complainant. The role of the complainant in the disciplinary process is limited to providing the board with factual information relative to the complaint. A complainant is not party to any

disciplinary proceeding which may be initiated by the board based in whole or in part on information provided by the complainant.

8.5(4) *Role of the board.* The board does not act as an arbiter of disputes between private parties, nor does the board initiate disciplinary proceedings to advance the private interest of any person or party. The role of the board in the disciplinary process is to protect the public by investigating complaints and initiating disciplinary proceedings in appropriate cases. The board possesses sole decision-making authority throughout the disciplinary process, including the authority to determine whether a case will be investigated, the manner of the investigation, whether a disciplinary proceeding will be initiated, and the appropriate licensee discipline to be imposed, if any.

8.5(5) *Initial complaint screening.* All written complaints received by the board shall be initially screened by the board's executive officer to determine whether the allegations of the complaint fall within the board's investigatory jurisdiction and whether the facts presented, if true, would constitute a basis for disciplinary action against a licensee. Complaints which are clearly outside the board's jurisdiction, which clearly do not allege facts upon which disciplinary action would be based, or which are frivolous shall be referred by the board's executive officer to the board for closure at the next scheduled board meeting. All other complaints shall be referred by the board's executive officer to the board's disciplinary committee for committee review as described in subrule 8.8(1).

193F—8.6(272C,543D) Case numbers. Whether based on written complaint received by the board or complaint initiated by the board, all complaint files shall be tracked by a case numbering system. Complaints are assigned case numbers in chronological order with the first two digits representing the year in which the complaint was received or initiated, and the second two digits representing the order in which the case file was opened (e.g., 01-01, 01-02, 01-03, etc.). The board's executive officer shall maintain a case file log noting the date each case file was opened, whether disciplinary proceedings were initiated in the case, and the final disposition of the case. Once a case file number is assigned to a complaint, all persons communicating with the board regarding that complaint are encouraged to include the case file number to facilitate accurate records and prompt response.

193F—8.7(272C,543D,546) Confidentiality of complaint and investigative information.

8.7(1) All complaint and investigative information received or created by the board is privileged and confidential pursuant to Iowa Code subsection 272C.6(4). Such information shall not be released to any person except as provided in that section and in this rule.

8.7(2) Disclosure to the subject of the investigation.

a. Legal authority. Pursuant to Iowa Code section 546.10(9), the board may, prior to the initiation of a disciplinary proceeding, supply to a licensee who is the subject of a disciplinary complaint or investigation all or such parts of a disciplinary complaint, disciplinary or investigatory file, report, or other information as the board in its sole discretion believes would aid the investigation or resolution of the matter.

b. General rule. As a matter of general policy, the board shall not disclose confidential complaint and investigative information to a licensee except as permitted by Iowa Code section 272C.6(4). Disclosure of a complainant's identity in advance of the filing of formal disciplinary charges, for instance, may adversely affect a complainant's willingness to file a complaint with the board.

c. Exceptions to general rule. The board may exercise its discretion to release to a licensee information that would otherwise be confidential under Iowa Code section 272C.6(4) under narrow circumstances, including but not limited to the following:

(1) Following a board determination that probable cause exists to file disciplinary charges against a licensee but prior to the issuance of the notice of hearing, the board may provide the licensee with a peer review report or investigative report or with expert opinions, as reasonably needed for the licensee to assess the merits of a settlement proposal.

(2) The board may release to a licensee who is the subject of a board-initiated investigation, including investigations initiated following the board's receipt of an anonymous complaint, such records or information as may aid the investigation or resolution of the matter.

(3) The board may disclose information from a peer review report or consultant's report when soliciting the licensee's position will aid in making the probable cause determination or when providing the information would be educational to the licensee, and such disclosure can be made to the licensee without revealing identifying information regarding the complainant, peer reviewer or consultant.

[ARC 0412C, IAB 10/31/12, effective 12/5/12]

193F—8.8(17A,272C,543D) Investigation procedures.

8.8(1) *Disciplinary committee.* The board chairperson shall annually appoint two to three members of the board to serve on the board's disciplinary committee. The disciplinary committee is a purely advisory body which shall review complaint files referred by the board's executive officer, generally supervise the investigation of complaints, and make recommendations to the full board on the disposition of complaints. Members of the committee shall not personally investigate complaints, but they may review the investigative work product of others in formulating recommendations to the board.

8.8(2) *Committee screening of complaints.* Upon the referral of a complaint from the board's executive officer or from the full board, the committee shall determine whether the complaint presents facts which, if true, suggest that a licensee may have violated a law or rule enforced by the board. If the committee concludes that the complaint does not present facts which suggest such a violation or that the complaint does not otherwise constitute an appropriate basis for disciplinary action, the committee shall refer the complaint to the full board with the recommendation that the complaint be closed with no further action. If the committee determines that the complaint does present a credible basis for disciplinary action, the committee may either immediately refer the complaint to the full board recommending that a disciplinary proceeding be commenced or initiate a disciplinary investigation.

8.8(3) *Committee procedures.* If the committee determines that additional information is necessary or desirable to evaluate the merits of a complaint, the committee may assign an investigator or expert consultant, appoint a peer review committee, provide the licensee an opportunity to appear before the disciplinary committee for an informal discussion as described in rule 193F—8.9(17A,272C,543D) or request board staff to conduct further investigation. Upon completion of an investigation, the investigator, expert consultant, peer review committee or board staff shall present a report to the committee. The committee shall review the report and determine what further action is necessary. The committee may:

- a. Request further investigation.
- b. Determine there is not probable cause to believe a disciplinary violation has occurred, and refer the case to the full board with the recommendation of closure.
- c. Determine there is probable cause to believe that a law or rule enforced by the board has been violated, but that disciplinary action is unwarranted on other grounds, and refer the case to the full board with the recommendation of closure. The committee may also recommend that the licensee be informally cautioned or educated about matters which could form the basis for disciplinary action in the future.
- d. Determine there is probable cause to believe a disciplinary violation has occurred, and refer the case to the full board with the recommendation that the board initiate a disciplinary proceeding (contested case).

8.8(4) *Subpoena authority.* Pursuant to Iowa Code sections 17A.13(1) and 272C.6(3), the board is authorized in connection with a disciplinary investigation to issue subpoenas to compel witnesses to testify or persons to produce books, papers, records and any other real evidence, whether or not privileged or confidential under law, which the board deems necessary as evidence in connection with a disciplinary proceeding or relevant to the decision about whether to initiate a disciplinary proceeding. Board procedures concerning investigative subpoenas are set forth in 193F—Chapter 19.

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—8.9(17A,272C,543D) Informal discussion. If the disciplinary committee considers it advisable, or if requested by the affected licensee, the committee may grant the licensee any opportunity to appear before the committee for a voluntary informal discussion of the facts and circumstances of an alleged violation, subject to the provisions of this rule.

8.9(1) An informal discussion is intended to provide a licensee an opportunity to share in an informal setting the licensee's side of a complaint before the board determines whether probable cause exists to initiate a disciplinary proceeding. Licensees are not required to attend an informal discussion. Because disciplinary investigations are confidential, licensees may not bring other persons with them to an informal discussion, but licensees may be represented by legal counsel.

8.9(2) Unless disqualification is waived by the licensee, board members or staff who personally investigate a disciplinary complaint are disqualified from making decisions or assisting the decision makers at a later formal hearing. Because board members generally rely upon investigators, peer review committees, or expert consultants to conduct investigations, the issue rarely arises. An informal discussion, however, is a form of investigation because it is conducted in a question and answer format. In order to preserve the ability of all board members to participate in board decision making and to receive the advice of staff, licensees who desire to attend an informal discussion must therefore waive their right to seek disqualification of a board member or staff based solely on the board member's or staff's participation in an informal discussion. Licensees would not be waiving their right to seek disqualification on any other ground. By electing to attend an informal discussion, a licensee accordingly agrees that participating board members or staff are not disqualified from acting as a presiding officer in a later contested case proceeding or from advising the decision maker.

8.9(3) Because an informal discussion constitutes a part of the board's investigation of a pending disciplinary case, the facts discussed at the informal discussion may be considered by the board in the event the matter proceeds to a contested case hearing and those facts are independently introduced into evidence.

8.9(4) The disciplinary committee, subject to board approval, may propose a consent order at the time of the informal discussion. If the licensee agrees to a consent order, a statement of charges shall be filed simultaneously with the consent order, as provided in rule 193F—20.4(17A,272C).

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—8.10(272C,543D) Peer review committee (PRC). A peer review committee may be appointed by the board to investigate a complaint. The committee may consist of one or more certified general or certified residential real property appraisers registered to practice in Iowa. The board may appoint a single peer review consultant to perform the functions of a PRC when, in the board's opinion, appointing a committee with more members would be impractical, unnecessary or undesirable given the nature of the expertise required, the need for prompt action or the circumstances of the complaint. An individual shall be ineligible as a PRC member in accordance with the standard for disqualification found in rule 193F—20.14(17A).

8.10(1) Authority. The PRC investigation may include activities such as interviewing the complainant, the respondent, and individuals with knowledge of the respondent's practice in the community; gathering documents; and performing independent analyses as deemed necessary. The board may give specific instructions to the PRC regarding the scope of the investigation. In the course of the investigation, PRC members shall refrain from advising the complainant or respondent on actions that the board might take.

8.10(2) Term of service. The PRC serves at the pleasure of the board. The board may dismiss any or all members of a PRC or add new members at any time.

8.10(3) Compensation. PRC members may receive compensation as the board may provide by contract. Within established budget limitations, PRC members may be reimbursed for reasonable and necessary expenses that are incurred for travel, meals and lodging while performing committee duties. The PRC shall not hire legal counsel, investigators, secretarial help or any other assistance without written authorization from the board.

8.10(4) Reports. Each PRC shall submit a written report to the board within a reasonable period of time.

8.10(5) Components of the report. The report shall include:

- a. Statement of the charge to the PRC;

b. Description of the actions taken by the PRC in its investigation, including but not limited to appraisal review(s) and interviews with the respondent or complainant;

c. Summary of the PRC's findings, including the PRC's opinion as to whether a violation occurred, citation of the specific USPAP violation(s), citation of the Iowa Code section(s) and Iowa Administrative Code rule(s) violated, and the PRC's opinion of the seriousness of the violation;

d. Recommendation.

8.10(6) Recommended action. The PRC report shall recommend one of the following:

a. Dismissal of the complaint;

b. Further investigation;

c. Disciplinary proceedings;

d. Allowing the appraiser who is the subject of the complaint an opportunity to appear before the board for an informal discussion regarding the circumstances of the alleged violation.

If the PRC recommends further investigation or disciplinary proceedings, supporting information must be submitted to the board including citation of the specific USPAP violation(s), Iowa Code section(s) and Iowa Administrative Code rule(s) violated.

8.10(7) Disciplinary recommendations. When recommending disciplinary proceedings, a PRC shall refrain from suggesting a particular form of discipline, but may provide guidance on the severity of the violations that prompted the recommendation and may identify professional areas in which the appraiser needs additional education or supervision in order to safely practice.

8.10(8) Confidentiality. The PRC shall not discuss its findings and conclusions with any party to the complaint other than the board (through its report to the board) or board staff. PRC findings including the name of the complainant shall be kept confidential at all times. PRC findings shall be used only for the purposes of the board's possible disciplinary action and not for any other court case, lawsuit, or investigation.

8.10(9) Testimony. In the event of formal disciplinary proceedings, PRC members may be required to testify.

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—8.11(17A,272C,543D) Closing complaint files.

8.11(1) Grounds for closing. Upon the recommendation of the executive officer, the recommendation of the disciplinary committee, or on its own motion, the board may close a complaint file, with or without prior investigation. Given the broad scope of matters about which members of the public may complain, it is not possible to catalog all possible reasons why the board may close a complaint file. The following nonexclusive list is, however, illustrative of the grounds upon which the board may close a complaint file:

a. The complaint alleges matters outside the board's jurisdiction.

b. The complaint does not allege a reasonable or credible basis to believe that the subject of the complaint violated a law or rule enforced by the board.

c. The complaint is frivolous or trivial.

d. The complaint alleges matters more appropriately resolved in a different forum, such as civil litigation to resolve a contract dispute, or more appropriately addressed by alternative procedures, such as outreach education or rule making.

e. The matters raised in the complaint are situational, isolated, or unrepresentative of a licensee's typical practice, and the licensee has taken appropriate steps to ensure future compliance and prevent public injury.

f. Resources are unavailable or better directed to other complaints or board initiatives in light of the board's overall budget and mission.

g. While the evidence may reveal one or more appraisal standards about which the appraiser should be more vigilant in the future, the issues appear correctable, are not likely to recur with proper diligence in the development and reporting of future appraisals, and do not reveal impediments to competent practice in the future.

h. Other extenuating factors exist which weigh against the imposition of public discipline when considered in the context of the board's purpose and mission.

8.11(2) Closing orders. The board's executive officer may enter an order stating the basis for the board's decision to close a complaint file. If entered, the order shall not contain the identity of the complainant or the respondent and shall not disclose confidential complaint or investigative information.

If entered, a closing order will be indexed by case number and shall be a public record pursuant to Iowa Code subsection 17.3(1) "d." A copy of the order may be mailed to the complainant, if any, and to the respondent. The board's decision whether or not to pursue an investigation, to institute disciplinary proceedings, or to close a file is not subject to judicial review.

8.11(3) Cautionary letters. The board may issue a confidential letter of caution to a licensee when a complaint file is closed which informally cautions or educates the licensee about matters which could form the basis for disciplinary action in the future if corrective action is not taken by the licensee. Informal cautionary letters do not constitute disciplinary action, but the board may take such letters into consideration in the future if a licensee continues a practice about which the licensee has been cautioned.

8.11(4) Reopening closed complaint files. The board may reopen a closed complaint file if additional information arises after closure which provides a basis to reassess the merits of the initial complaint.

193F—8.12(17A,272C,543D) Initiation of disciplinary proceedings. Disciplinary proceedings may only be initiated by the affirmative vote of a majority of a quorum of the board at a public meeting. Board members who are disqualified shall not be included in determining whether a quorum exists. If, for example, two members of the board are disqualified, three members of the board shall constitute a quorum of the remaining five board members for purposes of voting on the case in which the two members are disqualified. When three or more members of the board are disqualified or otherwise unavailable for any reason, the executive officer may request the special appointment of one or more substitute board members pursuant to Iowa Code section 17A.11, subsection 5. Discipline may only be imposed against a licensee by the affirmative vote of a majority of the members of the board who are not disqualified.

193F—8.13(17A,272C,543D) Disciplinary contested case procedures. Unless in conflict with a provision of board rules in this chapter, all of the procedures set forth in 193F—Chapter 20 shall apply to disciplinary contested cases initiated by the board.

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—8.14(543D) Decisions. The board shall make findings of fact and conclusions of law, and set forth the board's decision, order, or both in the case. The board's decision may include, without limitation, any of the following outcomes, either individually or in combination:

1. Dismiss the charges;
2. Suspend or revoke the appraiser's certification or associate's registration as authorized by law;
3. Impose civil penalties, the amount which shall be set at the discretion of the board, but which shall not exceed \$1000 per violation. Civil penalties may be imposed for any of the disciplinary violations specified in Iowa Code section 543D.17 and chapter 272C or for any repeat offenses;
4. Impose a period of probation, either with or without conditions;
5. Require reexamination;
6. Require additional professional education, reeducation, or continuing education;
7. Issue a citation and a warning;
8. Require desk review of the appraiser's work product;
9. Issue a consent order either with or without conditions;
10. Require consultation with one or more peer reviewers;
11. Revoke an appraiser's eligibility to supervise;
12. Require submission of monthly logs;
13. Impose any other form of discipline authorized by a provision of law that the board, in its discretion, believes is warranted under the circumstances of the case.

[ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—8.15(272C,543D) Mitigating and aggravating factors. Factors the board may consider when determining whether to impose discipline and what type of discipline to impose include:

8.15(1) History and background of respondent.

a. Whether the respondent was a registered associate appraiser or a certified appraiser at the time of the violation.

b. Prior disciplinary history or cautionary letters.

c. Length of certification or registration at the time of the violation.

d. Disciplinary history of current or prior supervisor.

e. Degree of cooperation with investigation.

f. Extent of self-initiated reform or remedial action after the date of the violation.

g. Whether the volume or geographic range of the respondent's practice is, or was at the time of the violation, reasonable under the circumstances.

h. Whether the respondent practiced with a lapsed, inactive, retired, suspended, revoked, or surrendered certificate or registration.

8.15(2) Nature of violation.

a. Length of time since the date of the violation.

b. Whether the violation is isolated or recurring.

c. Whether there are multiple violations or appraisals involved.

d. Whether the violation is in the nature of an error or situational carelessness or neglect, or reflects a more fundamental lack of familiarity with applicable appraisal methodology or standards.

e. Indicia of bad faith, false statements, deceptive practices, or willful and intentional acts, whether within the circumstances of the violation or in the course of the board's investigation or disciplinary proceeding.

f. Evidence of improper advocacy or other violation of the USPAP ethics rule or of Iowa Code section 543D.18 or 543D.18A(1).

g. The clarity of the issue or standard involved.

h. Whether the respondent practiced outside the scope of practice authorized by respondent's certification or registration.

i. Whether the violation relates to the respondent's supervisory role, the respondent's individual appraisal practice, or both.

8.15(3) Interest of the public.

a. Degree of financial or other harm to a client, consumer, lending institution, or others.

b. Risk of harm, whether or not the violation caused actual harm.

c. Economic or other benefit gained by respondent or by others as a result of the violation.

d. Deterrent impact of discipline.

e. Whether the respondent issued a corrected appraisal report when warranted.

[ARC 0412C, IAB 10/31/12, effective 12/5/12; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—8.16(272C,543D) Voluntary surrender. The board may accept the voluntary surrender of a license to resolve a pending disciplinary contested case or pending disciplinary investigation. The board shall not accept a voluntary surrender of a license to resolve a pending disciplinary investigation unless a statement of charges is filed along with the order accepting the voluntary surrender. Such voluntary surrender is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

193F—8.17(272C,543D) Reinstatement. In addition to the provisions of rule 193F—20.38(17A,272C), the following provisions shall apply to license reinstatement proceedings:

8.17(1) The board may grant an applicant's request to appear informally before the board prior to the issuance of a notice of hearing on an application to reinstate if the applicant requests an informal appearance in the application and agrees not to seek to disqualify, on the ground of personal investigation, board members or staff before whom the applicant appears.

8.17(2) An order granting an application for reinstatement may impose such terms and conditions as the board deems desirable, which may include one or more of the types of disciplinary sanctions described in rule 193F—8.14(543D).

8.17(3) The board shall not grant an application for reinstatement when the initial order which revoked, suspended or restricted the license, denied license renewal, or accepted a voluntary surrender was based on a criminal conviction and the applicant cannot demonstrate to the board's satisfaction that:

- a. All terms of the sentencing or other criminal order have been fully satisfied;
- b. The applicant has been released from confinement and any applicable probation or parole; and
- c. Restitution has been made or is reasonably in the process of being made to any victims of the crime.

[ARC 4379C, IAB 3/27/19, effective 5/1/19]

These rules are intended to implement Iowa Code sections 543D.5, 543D.17 and 543D.18 and chapters 17A and 272C.

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CHAPTER 9
RENEWAL, EXPIRATION AND REINSTATEMENT OF
CERTIFICATES AND REGISTRATIONS, RETIRED STATUS, AND INACTIVE STATUS
[Prior to 2/20/02, see rules 193F—4.2(543D) and 193F—4.5(543D)]

193F—9.1(272C,543D) Biennial renewal.

9.1(1) Certificates and associate registrations must be renewed on a biennial basis or they shall lapse.

9.1(2) Persons whose last names begin with A to K shall renew in even-numbered years. Persons whose last names begin with L to Z shall renew in odd-numbered years. Certificates and registrations shall expire biennially on June 30.

9.1(3) An application to renew a certificate or registration shall be submitted on a form obtained from the board office or on the board's website. Applicants may renew electronically through a board-established electronic process, as available.

9.1(4) With the exception of continuing education obtained during the 30-day grace period authorized by and subject to and in accordance with subrule 9.4(2), all continuing education claimed on a biennial renewal must have been acquired during the renewal period. In addition, all continuing education claimed on a biennial renewal must have been actually taken and completed prior to the renewal application being submitted to the board.

[ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—9.2(272C,543D) Notices.

9.2(1) It is the policy of the board to mail or send electronic renewal notices to certified and associate appraisers at the last address or email address on file with the board in the May preceding certificate or registration expiration. Neither the failure of the board to send such a notice nor the licensee's failure to receive such a notice shall excuse the requirement to timely renew and pay the renewal fee.

9.2(2) Certified and associate appraisers must ensure that their contact information on file with the board office is current and that the board is notified within 30 days of any address change, and report to the board all other addresses at which the appraiser engages in the business of preparing real estate appraisal reports, or any change in such information, within 30 calendar days of any addition or change thereto.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—9.3(272C,543D) Renewal procedures.

9.3(1) *Date of filing.* Certified and associate appraisers shall file a timely and sufficient renewal application with the board by the June 30 deadline in the biennial renewal year. An application shall be deemed filed on the date received by the board, the date of electronic submission or, if mailed, the date postmarked, but not the date metered. Applications to renew that are not timely received by the board shall be treated as applications to reinstate, as provided in rule 193F—9.4(272C,543D).

9.3(2) *Continuing education.* An applicant for renewal shall report the applicant's compliance with the continuing education requirements provided in 193F—Chapter 11. Full compliance with applicable continuing education requirements is a condition of renewal in active status. Applications to renew certificates or registrations in active status that do not, on their face, demonstrate full compliance with all applicable continuing education requirements shall be rejected as insufficient, as provided in subrule 9.3(4).

9.3(3) *Background disclosures.* An applicant for renewal shall disclose such background and character information as the board requests, which may include disciplinary action taken by any jurisdiction regarding a professional license of any type, the denial of an application for a professional license of any type by any jurisdiction, and the conviction of any crime.

9.3(4) *Insufficient applications.* The board shall reject applications that are insufficient. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:

a. Be on a form prescribed by the board or, in the event there are no paper forms, be submitted through the state's database;

- b. Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;
- c. Be fully completed;
- d. Reflect, on its face, full compliance with all applicable continuing education requirements; and
- e. Be accompanied by the proper fee. The fee shall be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is omitted or incorrect, the attempted credit card transaction is rejected, or the applicant's check is returned for insufficient funds or written on a closed account.

9.3(5) *Resubmission of rejected applications.* The board shall promptly notify an applicant of the basis for rejecting an insufficient renewal application, and shall return or refund any fees received. Applicants for certificate or registration renewal may remedy the insufficiency and resubmit applications that were rejected as insufficient. Resubmitted applications shall be deemed received when personally delivered to the board office, on the date of electronic submission or, if mailed, the date postmarked, but not the date metered. Resubmitted applications to renew that are not timely received by the board shall be treated as applications to reinstate, as provided in rule 193F—9.4(272C,543D).

9.3(6) *Administrative processing not determinative.* The administrative processing of an application to renew a certificate or registration shall not prevent the board from subsequently commencing a contested case to challenge the applicant's qualifications for continued licensure or to assert disciplinary charges if grounds exist to do so. The board may take such an action, for example, if an application to renew reflects full compliance with continuing education, but the licensee is unable to document compliance in a subsequent audit.

9.3(7) *Denial of timely and sufficient application to renew.* If grounds exist to deny a timely and sufficient application to renew, the board shall send written notification to the applicant stating the grounds for denial. The procedures described in rule 193F—20.40(546,543D,272C) shall apply.

[ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—9.4(272C,543D) Failure to renew.

9.4(1) The certificate or registration of a certified or associate appraiser shall lapse unless the appraiser submits a timely and sufficient renewal application by the expiration date.

9.4(2) A certified or associate appraiser may renew a certificate or registration after the expiration date by submitting a sufficient renewal application and biennial renewal fee, accompanied by the late renewal fee as provided in 193F—Chapter 12, within 30 calendar days of the expiration date. The board will allow the reinstatement of a lapsed certificate or registration during the 30-day period following expiration for an appraiser who did not complete all required continuing education during the prior biennium but who will have sufficient continuing education if courses completed during the 30-day period following lapse are included. The continuing education completed between July 1 and July 30 that fulfills a shortage of continuing education in the prior biennium shall not be counted toward the continuing education required in a subsequent renewal.

9.4(3) If a certified or associate appraiser fails to renew within the 30-day grace period provided for in subrule 9.4(2), the appraiser shall be required to reinstate in accordance with subrule 9.4(5).

9.4(4) Certified and associate appraisers are not authorized to practice or to hold themselves out to the public as certified or registered appraisers during the period of time that the certificate or registration is lapsed, including during the 30-day grace period following the lapse. Any violation of this subrule shall be grounds for discipline.

9.4(5) Reinstatement. The board may reinstate a lapsed certificate or registration upon the applicant's submission of an application to reinstate and completion of all of the following:

- a. Paying a penalty as provided in rule 193F—12.1(543D); and
- b. Paying the current renewal fee as provided in rule 193F—12.1(543D); and
- c. Paying the ASC National Registry fee as provided in rule 193F—12.1(543D); and

d. Providing evidence of completed continuing education outlined in rule 193F—11.2(272C,543D), as modified for associate appraisers in subrule 9.4(6), if the licensee wishes to reinstate to active status; and

e. Providing a written statement outlining the professional activities of the applicant in the state of Iowa during the period in which the applicant's certificate or registration was lapsed. The statement shall describe all appraisal services performed, with or without the use of the titles described in Iowa Code section 543D.15, for all appraisal assignments that are required by federal or state law, rule, or policy to be performed by a certified real estate appraiser.

9.4(6) Special continuing education requirements for reinstating associate appraisers. The board seeks to ensure that associate appraisers make progress toward full completion of all qualifying education required for eventual certification, as provided in rules 193F—5.2(543D) and 193F—6.2(543D). As a result, an associate appraiser applying to reinstate a registration that has been lapsed for 12 months or longer shall apply, in addition to the most recent 7-hour USPAP course, only qualifying education toward the continuing education required for reinstatement, until all qualifying education has been completed. All qualifying education taken as continuing education may also be applied as qualifying education toward certification. If the applicant has already completed all qualifying education or is required to have continuing education hours beyond those needed to fully complete all qualifying education, the applicant may use any approved continuing education course in addition to the mandatory 7-hour USPAP course. [ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—9.5(272C,543D) Inactive status.

9.5(1) General purpose. This rule establishes a procedure under which a person issued a certificate or associate registration may apply to the board to register in inactive status. Registration under this rule is available to a certificate holder or associate registrant residing within or outside the state of Iowa who is not engaged in Iowa in any practice for which a certificate or associate registration is required. A person eligible to register as inactive may, as an alternative to such registration, allow a certificate or associate registration to lapse. The board will continue to maintain a data base on persons registered as inactive, including information which may not routinely be maintained after a certificate or associate registration has lapsed through failure to renew. A person who registers as inactive will accordingly receive renewal applications, board newsletters and other mass communications from the board. Because a person registered in inactive status may not practice in Iowa or hold oneself out to the public as authorized to practice as a certified appraiser or registered associate appraiser, such person is not required to complete continuing education.

9.5(2) Eligibility. A person holding a lapsed or active certificate as a real property appraiser, or a lapsed or active registration as a registered associate, which has not been revoked or suspended may apply on forms provided by the board to register as inactive if the person is not engaged in the state of Iowa in any practice for which a certificate or associate registration is required. Such a person may be actively engaged in the practice of real estate appraising in another jurisdiction. Such a person may also engage in such appraisal practices as may be performed in Iowa by persons who do not hold a certificate as a real property appraiser or associate registration as long as the person does not hold oneself out to the public as a certified or associate real estate appraiser.

9.5(3) Affirmation. The application form shall contain a statement in which the applicant affirms that the applicant will not engage in any practice prohibited by subrule 9.5(2) in Iowa without first complying with all rules governing reactivation to active status. A person in inactive status may reactivate to active status at any time pursuant to subrule 9.5(6).

9.5(4) Renewal. A person registered as inactive may renew the person's certificate or associate registration to inactive status on the biennial schedule described in 193F—9.1(272C,543D). Such person is exempt from the continuing education requirements for renewal and will be charged a reduced rate, as provided in 193F—Chapter 12. An inactive certificate or associate registration shall lapse if not timely renewed. An active certificate holder or associate registrant may renew as inactive if such person has not completed all continuing education requirements and may thereafter apply for active status, through the reactivation process as provided in subrule 9.6(6), when the deficiency has been remedied.

9.5(5) *Grounds for discipline.* Certified and associate appraisers are not authorized to practice or to hold themselves out to the public as certified or registered appraisers during the period of time that the certificate or registration is in retired or inactive status. Any violation of this subrule shall be grounds for discipline.

9.5(6) *Reactivation.* A person registered as inactive shall apply to reactivate to active status prior to engaging in any practice in Iowa that requires certification or associate registration. An application to reactivate to active status shall be on a form provided by the board, shall demonstrate full compliance with all applicable continuing education requirements, and shall be accompanied by a fee to reactivate an inactive license and the biennial fee for active status as provided in rule 193F—12.1(543D). Prior to reactivation to active status, the applicant must complete all education that would have been required had the applicant been on active status, including the most recent seven-hour USPAP update course. All such continuing education must be verified whether or not the applicant has been in active practice in another jurisdiction. Additionally, the special continuing education requirements that apply to associate appraisers reinstating a lapsed registration, as provided in subrule 9.4(6), shall apply to associate appraisers reactivating to active status following a period of inactive status of 12 months or longer. Such an applicant shall be given credit for the most recent renewal fees previously paid if the applicant applies to reactivate in the same biennium at other than the applicant's regular renewal date. An applicant changing from active to inactive status during a biennial renewal period shall not, however, be entitled to a refund of any of the fees previously paid to attain active status.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—9.6(272C,543D) Retired status. An associate or certified appraiser may place the associate or certified appraiser's registration or certification in retired status. For purposes of this rule, the term "retired" means the person has retired from working as an associate or certified appraiser in all jurisdictions and has requested to be placed in retired status on forms provided by the board. An associate or certified appraiser in retired status may request that the registration or certification be placed into active status so long as the associate or certified appraiser has not renewed the registration or certification in inactive status or allowed the registration or certification to lapse prior to the request to return to active status. The board will not provide a refund of biennial registration and certification fees when an application for retired status is granted in a biennium in which the applicant has previously paid the biennial fees for either active or inactive status. Associate and certified appraisers in retired status are exempt from the renewal requirement. While in retired status, appraisers may not hold themselves out to the public as being registered or certified appraisers during the period of time that the registration or certification is in retired status. For all intents and purposes, retired status is similar to lapsed status with the exceptions that:

9.6(1) The associate or certified appraiser may place the associate or certified appraiser's registration or certification in retired status at any point;

9.6(2) Until such time as the registration or certification expires, the applicant will not be subject to the reactivation or reinstatement criteria;

9.6(3) If the associate or certified appraiser places the registration or certification into inactive status at the time of renewal, or the applicant lets the registration or certification lapse, the applicant will be required to reactivate or reinstate pursuant to rule 193F—4.6(272C,543D), or subrule 9.4(5) or 9.5(6) as applicable.

[ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—9.7(272C,543D) Property of the board. Every certificate or associate registration issued by the board shall, while it remains in the possession of the holder, be preserved by the holder but shall, nevertheless, always remain the property of the board. In the event that a certificate or associate registration is revoked or suspended, is not renewed, is registered in inactive status, or is placed in retired status, it shall, on demand, be delivered by the holder to the board. The board shall generally not request return of a certificate or associate registration if it has not been revoked, suspended or voluntarily surrendered in a disciplinary action, but may do so if the board reasonably determines

that grounds exist to believe that a person holding a lapsed, retired, or inactive certificate or associate registration has engaged in a practice for which active certification or registration is required.

[ARC 5785C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code section 543D.5.

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[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 10
RECIPROCITY

[Prior to 2/20/02, see 193F—Chapter 5]

193F—10.1(543D) Nonresident certification by reciprocity.

10.1(1) A nonresident of Iowa seeking certification in this state shall apply on forms provided by the board and pay the appropriate fee required in rule 193F—12.1(543D).

10.1(2) The board may issue a reciprocal certificate to a nonresident individual who is certified and demonstrates good standing in another state. An appraiser who is listed in good standing on the National Registry of the Appraisal Subcommittee satisfies the requirement that good standing be demonstrated and does not need to submit additional documentation. An appraiser who is not listed in good standing on the National Registry of the Appraisal Subcommittee must supply an official letter of good standing issued by the licensing board of the appraiser's resident state and bearing its seal. An appraiser may verify the appraiser's status on the National Registry of the Appraisal Subcommittee by accessing the ASC's website.

10.1(3) A reciprocal certified appraiser shall comply with all provisions of Iowa law and rules.

10.1(4) Reciprocal certified appraisers shall be required to pay the federal registry fee as required in rule 193F—12.3(543D).

[ARC 1197C, IAB 11/27/13, effective 1/1/14; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—10.2(543D) Nonresident temporary practice.

10.2(1) The board will recognize, on a temporary basis, the certification of an appraiser issued by another state for a period of six months, unless the applicant requests, and is approved for, a one-time extension, of which the one-time extension will not exceed six months, prior to the expiration of the original issued temporary practice permit.

10.2(2) The appraiser must register with the board and identify the property(ies) to be appraised and the name and address of the client. The appraiser must demonstrate good standing to be considered for a temporary practice permit. An appraiser who is listed in good standing on the National Registry of the Appraisal Subcommittee satisfies the requirement that good standing be demonstrated and does not need to submit additional documentation. An appraiser who is not listed in good standing on the National Registry of the Appraisal Subcommittee must supply an official letter of good standing issued by the licensing board of the appraiser's resident state and bearing its seal. An appraiser may verify the appraiser's status on the National Registry of the Appraisal Subcommittee by accessing the ASC's website. Registration shall be on a form provided by the board and submitted to the board office prior to the performance of the appraisal. The appraiser shall pay the appropriate fee as required in rule 193F—12.1(543D).

10.2(3) An appraiser holding an inactive, retired, or lapsed certificate as a real estate appraiser in Iowa may apply for a temporary practice permit if the appraiser holds an active, unexpired certificate as a real estate appraiser in good standing in another jurisdiction and is otherwise eligible for a temporary practice permit.

10.2(4) An appraiser who was previously a registered associate or certified appraiser in Iowa whose Iowa registration or certificate has been revoked or surrendered in connection with a disciplinary investigation or proceeding is ineligible to apply for a temporary practice permit in Iowa.

10.2(5) The board may deny an application for a temporary practice permit if the applicant has been disciplined in Iowa or another jurisdiction, a disciplinary investigation or proceeding is pending in Iowa, the person has been convicted of a crime that is a ground for discipline in Iowa, or it appears the applicant is applying for a temporary permit because the applicant would not qualify to renew or reinstate in active status in Iowa and the application for a temporary permit is made primarily to compromise compliance with Iowa laws and rules.

10.2(6) An appraiser holding an inactive, retired, or lapsed Iowa certificate who applies to reinstate to active status in Iowa shall not be given credit for any fees paid during the biennial period for one or more temporary practice permits.

10.2(7) An appraiser holding a license to practice as a real estate appraiser in another jurisdiction may practice in Iowa without applying for a temporary practice permit or paying any fees as long as the appraiser does not perform appraisal services in Iowa for which certification is required by state or federal law, rule or policy.

10.2(8) The board must receive and approve an application for a temporary practice permit before the applicant is eligible to practice in Iowa under a temporary practice permit. Applicants are encouraged to submit applications by email or facsimile to avoid the possible delays of mail service, because the board will not approve an application with a retroactive start date. The board shall grant or deny all applications for temporary practice permits as quickly as reasonably feasible and no later than five days of receipt of a completed application. Applicants shall use the form prescribed by the board. Applicants disclosing discipline or criminal convictions shall attach documentation from which the board can determine if the discipline or criminal history would be a ground to deny the application. Falsification of information or failure to disclose material information shall be a ground to deny the application and may form the basis to deny any subsequent application or an application to reinstate a lapsed or inactive Iowa certificate.

[ARC 9865B, IAB 11/30/11, effective 1/4/12; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code sections 543D.10 and 543D.11.

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[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 11
CONTINUING EDUCATION
[Prior to 2/20/02, see 193F—Chapter 6]

193F—11.1(272C,543D) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Approved program*” means a continuing education program, course, or activity that satisfies the standards set forth in these rules and has received advance approval of the board pursuant to these rules.

“*Approved provider*” means a person or an organization that has been approved by the board to conduct continuing education programs pursuant to these rules.

“*Board*” means the Iowa real estate appraiser examining board.

“*Continuing education*” means education which is obtained by a person certified to practice real estate appraising in order to maintain, improve, or expand skills and knowledge obtained prior to initial certification or registration, or to develop new and relevant skills and knowledge, all as a condition of renewal.

“*Credit hour*” means the value assigned by the board to a continuing education program.

“*Distance education*” means any education process based on the geographical separation of student and instructor. “Distance education” includes computer-generated programs and webinars.

“*Guest speaker*” means an individual who teaches an appraisal education program on a one-time-only or very limited basis and who possesses a unique depth of knowledge and experience in the subject matter.

“*Hour*” means 50 minutes of instruction.

“*Live instruction*” means an educational program delivered in a classroom setting where both the student and the instructor are present in the same room.

[ARC 9865B, IAB 11/30/11, effective 1/4/12; ARC 1732C, IAB 11/12/14, effective 12/17/14]

193F—11.2(272C,543D) Continuing education requirements.

11.2(1) Certified residential, certified general and associate appraisers must demonstrate compliance with the following continuing education requirements as a condition of biennial renewal:

a. A minimum of 28 credit hours in approved continuing education programs must be acquired during the two-year renewal period. Carryover hours from a previous renewal period are not allowed.

b. The purpose of continuing education is to ensure that the appraiser participates in a program that maintains and increases the appraiser’s skill, knowledge and competency in real estate appraising. Credit may be granted for educational offerings that are consistent with the purpose of continuing education. A minimum of 21 of the required 28 credit hours must involve courses that address one or more of the subject areas listed in subrule 11.4(2).

c. Appraisers must successfully complete the seven-hour National USPAP Update Course, or its equivalent, each two-year renewal cycle. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP continuing education credit shall be awarded only when the class is instructed by an AQB-certified instructor(s) and when the class is instructed by at least one state-certified residential or state-certified general appraiser. Individuals who are credentialed in more than one jurisdiction shall not have to take more than one seven-hour National USPAP Update Course within a two-calendar-year period for the purposes of meeting AQB criteria.

d. With the exception of continuing education obtained during the 30-day grace period authorized by and subject to and in accordance with 193F—subrule 9.4(2), all continuing education claimed on a biennial renewal must have been acquired during the renewal period. In addition, all continuing education claimed on a biennial renewal must have been actually taken and completed prior to the renewal application being submitted to the board.

11.2(2) All continuing education credit hours may be acquired in approved classroom or distance education programs.

11.2(3) A maximum of 14 of the required 28 credit hours may be claimed by an instructor for teaching one or more approved continuing education programs in an amount equal to the credit hours

approved for attendees. Instructors claiming such credit must teach the appraisal course during the renewal cycle in which credit is claimed and may not claim the course more than once in the renewal cycle. The board may request supportive documentation to ascertain course content and to verify the date(s), time, place and hours taught.

11.2(4) An applicant seeking to renew an initial certificate or registration issued less than 185 days prior to renewal is not required to report any continuing education. An applicant seeking to renew an initial certificate or registration issued for 185 days to 365 days prior to renewal must demonstrate completion of at least 14 credit hours, including 7 credit hours of the most recent National USPAP Update. An applicant seeking to renew an initial certificate or registration issued 365 days prior to renewal or more must demonstrate completion of at least 28 credit hours, including 7 credit hours of the most recent National USPAP Update.

11.2(5) Prior to reinstatement or reactivation of a certified general registration or a certified residential registration, a certified credential holder in inactive, retired, or lapsed status must complete all required continuing education hours that would have been required if the certified credential holder was in active status. The required hours must also include the most recent edition of a seven-hour National USPAP Update Course. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements.

11.2(6) During each two-year renewal period, a continuing education program may be taken for credit only once, except USPAP courses as long as it is not the same USPAP course (e.g., an appraiser may take the 2018-2019 USPAP and the 2020-2021 USPAP update course but may not take two 2018-2019 USPAP update courses).

11.2(7) Successful completion of a continuing education program requires that at least 50 minutes of every class hour be attended by the student. Continuing education credits shall not be granted to attendees who are present for less than 50 minutes of every class hour.

11.2(8) An applicant may claim continuing education credits that have been approved by another jurisdiction that has a continuing education requirement for renewal of a real estate appraisal certificate if the applicable program was approved by the other jurisdiction's appraisal regulatory body or the AQB for continuing education purposes at the time the applicant completed the course. The burden of proof is on the applicant to demonstrate that a claimed course was approved by either the other jurisdiction or the AQB for continuing education purposes at the time the applicant completed the course. All other programs must be approved upon application to the board pursuant to rules 193F—11.4(272C,543D), 193F—11.5(272C,543D) and 193F—11.6(272C,543D).

11.2(9) A person certified or registered to practice real estate appraising in Iowa shall be deemed to have complied with Iowa's continuing education requirements for periods in which the person is a resident of another state or district having continuing education requirements for real estate appraising and meets all requirements of that state or district. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements. Deferrals may not be granted to credential holders, except in the case of persons returning from active military duty. Credential holders returning from active military duty may be placed in active status for a period of up to 90 days pending completion of all continuing education requirements. To qualify, the credential holder must submit a request in writing and provide a copy of the military orders.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 9865B, IAB 11/30/11, effective 1/4/12; ARC 0412C, IAB 10/31/12, effective 12/5/12; ARC 0635C, IAB 3/6/13, effective 4/10/13; ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—11.3(272C,543D) Hardship and disability provisions. Rescinded IAB 5/20/09, effective 6/24/09.

193F—11.4(272C,543D) Minimum program qualifications.

11.4(1) Continuing education programs, as a condition of board approval, must provide a formal program of learning that contributes to the growth in the professional knowledge and professional competence of real estate appraisers.

11.4(2) Continuing education programs dealing with the following subject areas that are integrally related to appraisal topics and that will generally be acceptable include, but are not limited to:

- a. Ad valorem taxation;
- b. Agriculture production and economics;
- c. Agronomy/soil;
- d. Approaches to value;
- e. Arbitrations, dispute resolution;
- f. Courses related to the practice of real estate appraisal or consulting;
- g. Construction cost or development cost estimating;
- h. Ethics and standards of professional practice, USPAP;
- i. Land use planning or zoning;
- j. Management, leasing, time sharing;
- k. Property development, partial interests;
- l. Real estate appraisal law and rules;
- m. Real estate appraisal (valuations/evaluations);
- n. Real estate law, easements, and legal interests;
- o. Real estate litigation, damages, condemnation;
- p. Real estate financing and investment;
- q. Real estate appraisal-related computer applications;
- r. Real estate securities and syndication;
- s. Developing opinions of real property value in appraisals that also include personal property or business value, or both;
- t. Seller concessions and impact on value;
- u. Energy efficient items and “green building” appraisals; and
- v. Real estate appraisal technology (e.g., drones).

11.4(3) The following programs will not be acceptable:

- a. Sales promotion meetings held in conjunction with the appraiser’s general business;
- b. Time devoted to breakfast, lunch or dinner;
- c. A program certified by the use of a challenge examination. The required number of hours must be completed to receive credit hours;
- d. Programs that do not provide at least two credit hours.

11.4(4) Continuing education credit will be granted only for whole hours, with a minimum of 50 minutes constituting one hour. For example, 100 minutes of continuous instruction would count as two credit hours; however, more than 50 minutes but less than 100 minutes of continuous instruction would only count as one hour.

11.4(5) Continuing education credit may be approved for university or college courses in qualifying topics according to the following formula: Each semester hour of credit shall equal 15 credit hours and each quarter hour of credit shall equal 10 credit hours.

[ARC 9865B, IAB 11/30/11, effective 1/4/12; ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—11.5(272C,543D) Standards for provider and program approval. Providers and programs must satisfy the following minimum standards in order to be preapproved in accordance with the procedures established in rule 193F—11.4(272C,543D) and in order to maintain approved status.

11.5(1) The program must be taught or developed by individuals who have the education, training and experience to be considered experts in the subject matter of the program and competent in the use of teaching methods appropriate to the program.

11.5(2) Live instruction programs must be taught by instructors who have successfully completed an instructor development workshop within 24 months preceding board approval of the program. Certified USPAP instructors shall be considered to have met this requirement.

11.5(3) In determining whether an instructor is qualified to teach a particular program, the board will consider whether the instructor has an ability to teach and an in-depth knowledge of the subject matter.

11.5(4) An instructor may demonstrate the ability to teach by meeting one or more of the following criteria:

- a. Hold a bachelor's degree or higher in education from an accredited college (attach a copy of transcripts);
- b. Hold a current teaching credential or certificate in any real estate or real estate-related fields (attach copy);
- c. Hold a certificate of completion in the area of instruction from an instructor institute, workshop or school that is sponsored by a member of the Appraisal Foundation (detail specific teaching experiences);
- d. Hold a full-time current appointment to the faculty of an accredited college;
- e. Other, as the board may determine.

11.5(5) An instructor may demonstrate in-depth knowledge of the program's subject matter by meeting one or more of the following criteria:

- a. Hold a bachelor's degree or higher from an accredited college with a major in a field of study directly related to the subject matter of the course the instructor proposes to teach, such as business, economics, accounting, real estate or finance (attach copy of transcript);
- b. Hold a bachelor's degree or higher from an accredited college and have five years of appraisal experience related to the subject matter of the course the instructor proposes to teach (attach copy of transcript and document how the instructor's experience is related to the subject matter the instructor proposes to teach);
- c. Hold a generally recognized professional real property appraisal designation or be a sponsor member of the Appraisal Foundation;
- d. Other, as the board may determine.

11.5(6) Only AQB-certified USPAP instructors, listed on the website of the Appraisal Foundation may teach the national USPAP courses including the 15-hour tested course and the 7-hour continuing education course.

11.5(7) Course content and materials must be accurate, consistent with currently accepted standards relating to the program's subject matter and updated no later than 30 days after the effective date of a change in standards, laws or rules.

11.5(8) Programs must have an appropriate means of written evaluation by participants. Evaluations shall include the relevance of the materials, effectiveness of presentation, content, facilities, and such additional features as are appropriate to the nature of the program.

11.5(9) No part of any course shall be used to solicit memberships in organizations, recruit appraisers for affiliation with any organization or advertise the merits of any organization or sell any product or service.

11.5(10) Providers must clearly inform prospective participants of the number of credit hours preapproved by the board for each program and all applicable policies concerning registration, payment, refunds, attendance requirements and examination grading.

11.5(11) Procedures must be in place to monitor whether the person receiving credit hours is the person who attended or completed the program.

11.5(12) Providers must be accessible to students during normal business hours to answer questions and provide assistance as necessary.

11.5(13) Providers must comply with or demonstrate exemption from the provisions of Iowa Code sections 714.14 to 714.25.

11.5(14) Providers must designate a coordinator in charge of each program who will act as the board's contact on all compliance issues.

11.5(15) Programs shall not offer more than eight credit hours in a single day.

11.5(16) Providers shall not provide any information to the board, the public or prospective students which is misleading in nature. For example, providers may not refer to themselves as a "college" or "university" unless qualified as such under Iowa law.

11.5(17) Providers must establish and maintain for a period of five years complete and detailed records on the programs successfully attended by each Iowa participant.

11.5(18) Providers must issue an individual certificate of attendance to each participant upon successful completion of the program. The certificate must be no larger than 8½" × 11" and must include the provider name and number, program name and number, name of attendee, date program was completed, number of approved credit hours, and the signature of the coordinator or other person authorized by the board.

11.5(19) Program providers and instructors are solely responsible for the accuracy of all program materials, instruction and examinations. Board approval of a provider or program is not an assurance or warranty of accuracy and shall not be explicitly or implicitly marketed or advertised as such.

11.5(20) Providers must apply for approval using forms prescribed by the board.
[ARC 1732C, IAB 11/12/14, effective 12/17/14]

193F—11.6(272C,543D) Acceptable distance education courses. Distance education is an education process based on the geographical separation of student and instructor. A distance education course is acceptable to meet class hour requirements if:

11.6(1) The course provides interaction. Interaction is a reciprocal environment in which the student has verbal or written communication with the instructor; and

11.6(2) Content approval is obtained from the AQB, a state licensing jurisdiction, or an accredited college, community college, or university that offers distance education programs and is approved or accredited by the Commission on Colleges, a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education. Nonacademic credit college courses provided by a college shall be approved by the AQB or the state licensing jurisdiction; and

11.6(3) Course delivery mechanism approval is obtained from one of the following sources:

- a. AQB-approved organizations providing approval of course design and delivery; or
- b. A college or university that qualifies for content approval pursuant to subrule 11.6(2) that awards academic credit for the distance education course; or
- c. A qualifying college or university for content approval with a distance education delivery program that approves the course design and delivery that incorporate interactivity.

11.6(4) Distance education courses must include at least one of the following:

- a. A written examination proctored by an official approved by the college or university, or by the sponsoring organization. The term "written" in this subrule refers to an examination that may be written on paper or administered electronically on a computer or other device. Oral examinations are not acceptable.
- b. Successful completion of prescribed course mechanisms required to demonstrate knowledge of the subject matter.

[ARC 1732C, IAB 11/12/14, effective 12/17/14]

193F—11.7(272C,543D) Applications for approval of programs. Applications for approval of programs must be submitted on forms prescribed by the board. All non-AQB courses are approved for 24 months, including the month of approval. AQB-approved courses are approved through the AQB expiration date, which may be longer than 24 months from the date of approval.

11.7(1) Approval must be obtained for each program separately.

11.7(2) A nonrefundable fee of \$50 must be submitted for each program except for programs that are submitted for approval by the primary provider and that have been approved by the Appraiser Qualifications Board through the Course Approval Program (CAP).

11.7(3) All required forms and attachments must be submitted for approval at least 30 days prior to the first offering of each program. The board will approve or deny each program, in whole or part, within 15 days of the date the board receives a fully completed application. Payments for course program applications must be made within 30 calendar days of the date the application is approved by the board or the application approval may be reversed.

11.7(4) Application forms for non-AQB CAP courses will request information including, but not limited to, the following:

- a. Program description;
- b. Program purpose;

- c.* Learning objectives that specify the level of knowledge or competency the student should demonstrate upon completing the program;
- d.* Description of the instructional methods utilized to accomplish the learning objective;
- e.* Identifying information for all guest speakers or instructors and such documentation as is necessary to verify compliance with the instructor qualifications described in subrule 11.5(5);
- f.* Copies of all instructor and student program materials;
- g.* Copies of all examinations and a description of all grading procedures;
- h.* A description of the diagnostic assessment method(s) used when examinations are not given;
- i.* Such information as needed to verify compliance with board rules;
- j.* The name, address, telephone number, and email address for the program's coordinator;
- k.* Such other information as the board deems reasonably needed for informed decision making.

11.7(5) Application forms for courses that are AQB CAP-approved shall include information as deemed necessary for accurate documentation but may be more limited than information required in subrule 11.7(4).

11.7(6) The board shall assign each provider and program a number. This number shall be placed on all correspondence with the board, all subsequent applications by the same provider, and all certificates of attendance issued to participants.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—11.8(272C,543D) Waiver of application fees. Application fees may be waived for approved programs sponsored by a federal, state, or local governmental agency when the program is offered at no cost or at a nominal cost to participants. A request for waiver of application fees should be made by the provider or certificate holder at the time the application is filed with the board.

193F—11.9(272C,543D) Authority to approve education. The executive officer has the authority to approve or deny education applications subject to the applicant's right to a hearing as provided for in rule 193F—11.13(272C,543D).

[ARC 1732C, IAB 11/12/14, effective 12/17/14]

193F—11.10(272C,543D) Appraiser request for preapproval of continuing education programs. An appraiser seeking credit for attendance and participation in a program which is to be conducted by a provider not accredited or otherwise approved by the board shall apply for approval to the board at least 15 days in advance of the commencement of the activity. The board shall approve or deny the application in writing. Application for prior approval of a continuing education activity shall include the following fee and information:

1. Application fee of \$25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title and hour-by-hour outline of the program, course or activity;
5. Credit hours requested for approval;
6. Date of program; and
7. Principal instructor(s).

193F—11.11(272C,543D) Appraiser request for postapproval of continuing education program. An appraiser seeking credit for attendance and participation in a program that was not conducted by an approved provider or approved by the licensing authority in another state or otherwise approved by the board shall submit to the board a request for credit for the program. Within 15 days after receipt of the request, the board shall advise the requester in writing whether the program is approved and the number of hours allowed. Appraisers not complying with the requirement of this rule may be denied credit for the program. Application for postapproval of a continuing education program shall include the following fee and information:

1. Application fee of \$25;
2. School, firm, organization or person conducting the program;

3. Location of the program;
4. Title of program and description of program;
5. Credit hours requested for approval;
6. Dates of program;
7. Principal instructor(s); and
8. Verification of attendance.

193F—11.12(272C,543D) Review of provider or program. The board on its own motion or upon receipt of a complaint or negative evaluation may monitor or review any approved program or provider and, upon evidence of significant variation in the program presented from the program approved, a violation of board rules, or material misstatement or omission in the application form, may withdraw approval of the provider or program and disallow all or any part of the approved hours granted to the provider. The provider, as a condition of approval, agrees to allow the board or its authorized representatives to monitor ongoing compliance with board rules through means including, but not limited to, unannounced attendance at programs.

193F—11.13(272C,543D) Hearings. In the event of denial, in whole or in part, of any application for approval of a continuing education program or provider, or credit for a continuing education program, or withdrawal of approval of a continuing education program or provider, the provider or appraiser may, within 30 days of the date of mailing of the notice of denial or withdrawal, request a contested case hearing before the board, as provided in rule 193F—20.8(17A).

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 4379C, IAB 3/27/19, effective 5/1/19]

These rules are intended to implement Iowa Code sections 543D.5, 543D.9 and 543D.16 and chapter 272C.

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[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 12

FEES

[Prior to 2/20/02, see 193F—Chapter 10]

193F—12.1(543D) Required fees. The following fee schedule applies to certified general, certified residential and associate appraisers.

Initial examination application fee	\$150
Examination fee (and reexamination fee)	\$145
Biennial registration fee for active status (initial, reciprocal, renewal):	
Certified real property appraiser > one year	\$200
Certified real property appraiser < one year	\$100
Associate real property appraiser > one year	\$200
Associate real property appraiser < one year	\$100
Biennial registration fee for inactive status (initial, reciprocal, renewal):	
Certified real property appraiser	\$100
Associate real property appraiser	\$50
Temporary practice permit fee (each request)	\$100
Fee to reinstate a lapsed or retired license (lapsed or retired to active status)	\$150 (plus the registration fee)
Fee to reactivate an inactive or retired license (inactive or retired to active status)	\$50 (plus the registration fee)
Formal wall certificate	\$25
Work product review fees:	
Original submission, certified residential	\$300
Original submission, certified general	\$650
Additional residential reports as requested by the board	\$150 per report
Additional nonresidential reports as requested by the board	\$250 per report
Voluntary submission of residential reports for review	\$150 per report
Voluntary submission of nonresidential reports for review	\$250 per report
Course application fee (non-AQB-approved courses and secondary providers)	\$50
Pre-/post-course application fee	\$25
Background check	\$51

ASC National Registry fee > one year, separate from registration fee	\$80
ASC National Registry fee < one year, separate from registration fee	\$40
Fee to add supervisory appraiser	\$25
Fee to add course instructor	\$10
Waiver to administrative rules	\$25
Late renewal fee (associate, certified)	\$50

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 9667B, IAB 8/10/11, effective 9/14/11; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

193F—12.2(543D) Prorating of registration fees. An applicant applying for initial or reciprocal registration or certification within 12 months from the applicant's required renewal date, pursuant to rule 193F—9.1(543D), shall pay half the required fee. An applicant applying for initial or reciprocal registration or certification more than 12 months from the applicant's required renewal date shall pay the full registration fee. An applicant applying to reinstate or reactivate a lapsed registration or certification within 12 months from the applicant's required renewal date, pursuant to rule 193F—9.1(543D), shall pay half the required renewal fee plus the applicable reactivation or reinstatement fee. An applicant applying to reinstate or reactivate a lapsed registration or certification more than 12 months from the applicant's required renewal date shall pay the full renewal fee plus the applicable reactivation or reinstatement fee.

[ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—12.3(543D) Federal registry fee. The board shall collect and transmit to the Appraisal Subcommittee of the Federal Financial Institutions Examination Council, on an annual basis, a roster of individuals who have received certification or registration as real property appraisers and a registry fee of \$40 for each individual listed on the roster.

[ARC 9667B, IAB 8/10/11, effective 9/14/11; ARC 5785C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code section 543D.6.

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EDUCATIONAL EXAMINERS BOARD[282]

[Prior to 6/15/88, see Professional Teaching Practices Commission[640]]

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CHAPTER 13
ISSUANCE OF TEACHER LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—13.1(272) All applicants desiring Iowa licensure.

13.1(1) Definitions.

“*Coursework*” means requirements completed for semester hour credit through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*Degree*” means a specific qualification earned by a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*Nontraditional*” means any method of teacher preparation that falls outside the traditional method of preparing teachers.

“*Proficiency*,” for the purposes of paragraph 13.5(2)“*e*,” means that an applicant has passed all parts of the standard.

“*Recognized non-Iowa teacher preparation institution*” means an institution that is state-approved and accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*State-approved*” means a program for teacher preparation approved for state licensure.

“*Traditional*” means a one- or two-year sequenced teacher preparation program of instruction taught at a state-approved college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education that includes commonly recognized pedagogy classes coursework and requires a student teaching component.

13.1(2) Licenses, authorizations, certificates, and statements of professional recognition. Licenses, authorizations, certificates, and statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

a. National criminal history background check. An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

b. Iowa division of criminal investigation background check. An Iowa division of criminal investigation (DCI) background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

c. Registries and records check. A check of the following registries and records will be conducted on initial applicants: the sex offender registry under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the information in the Iowa court information system available to the general public. The fee for checks of these registries and records will be assessed to the applicant.

13.1(3) Temporary permits. The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check and registries and records check set forth in paragraphs 13.1(2)“*b*” and “*c*.” The temporary permit shall serve as evidence of the applicant’s authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

[ARC 0563C, IAB 1/23/13, effective 1/1/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—13.2(272) Applicants from recognized Iowa institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.3(272) Applicants from non-Iowa institutions. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.4(272) Applicants from foreign institutions. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.5(272) Teacher licenses. A license may be issued to an applicant who fulfills the general requirements set out in subrule 13.5(1) and the specific requirements set out for each license.

13.5(1) General requirements. The applicant shall:

- a. Have a baccalaureate degree.
- b. Have completed a state-approved teacher education program.
- c. Have completed the teacher preparation coursework set forth in 281—subrules 79.15(2) to 79.15(5).
- d. Have completed student teaching in the subject area and grade level endorsement desired.
- e. Have completed the requirements for one of the basic teaching endorsements.
- f. Provide a recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed.

13.5(2) Applicants from non-Iowa institutions.

a. Original application. Applicants under this subrule have completed a teacher preparation program outside the state of Iowa and are applying for their first Iowa teaching license.

b. In addition to the requirements set forth in subrule 13.5(1), an applicant from a non-Iowa institution:

(1) Shall submit a copy of a valid or expired regular teaching certificate or license exclusive of a temporary, emergency or substitute license or certificate.

(2) Shall provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013, and the applicant has verified fewer than three years of valid out-of-state teaching experience. If the teacher preparation program was completed prior to January 1, 2013, or if the applicant has verified three years of valid out-of-state teaching experience, the applicant must provide verification of successfully passing the mandated assessment(s) in the state in which the applicant is currently licensed (or verify highly qualified status) or must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.

(3) Shall provide an official institutional transcript(s) to be analyzed for the requirements necessary for Iowa licensure. An applicant must have completed at least 75 percent of the coursework as outlined in 281—subrules 79.15(2) to 79.15(5) and an endorsement requirement through a two- or four-year institution in order for the endorsement to be included on the license. An applicant who has not completed at least 75 percent of the coursework for at least one of the basic Iowa teaching endorsements completed will not be issued a license. An applicant seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for licensure. An applicant who has met the minimum coursework requirements in this subrule will not be subject to additional coursework deficiency requirements if the applicant provides verification of ten years of successful teaching experience or if the applicant provides verification of five years of successful experience and a master's degree.

(4) Shall demonstrate recency of experience by providing verification of either one year of teaching experience or six semester hours of college credit during the five-year period immediately preceding the date of application.

(5) Shall not be subject to any pending disciplinary proceedings in any state or country.

(6) Shall comply with all requirements with regard to application processes and payment of licensure fees.

c. If through a transcript analysis, the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) or one of the basic teaching endorsement requirements for Iowa is not met, the

applicant may be eligible for the equivalent Iowa endorsement areas, as designated by the Iowa board of educational examiners, based on current and valid National Board Certification.

d. If the teacher preparation program was considered nontraditional, candidates will be asked to verify the following:

- (1) That the program was for secondary education;
- (2) A baccalaureate degree with a cumulative grade point average of 2.50 on a 4.0 scale; and
- (3) The completion of a student teaching or internship experience or three years of teaching experience.

e. If the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) cannot be reviewed through a traditional transcript evaluation, a portfolio review and evaluation process may be utilized.

(1) An applicant must demonstrate proficiency in a minimum of at least 75 percent of the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5).

(2) An applicant must meet with the board of educational examiners to answer any of the board's questions concerning the portfolio.

f. An applicant under this subrule or subrule 13.5(3) shall be granted an Iowa teaching license and will not be subject to additional assessments or coursework deficiencies if the following additional requirements have been met:

(1) Verification of Iowa residency, or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired regular teaching certificate or license in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate. Endorsements shall be granted based on comparable Iowa endorsements, and endorsement requirements may be waived in order to grant the most comparable endorsement.

(3) Passing test scores for the required assessments for the state where the teaching license was issued.

g. Holders of an Iowa regional exchange license issued prior to January 1, 2021, may submit a new application if the requirements in this subrule would have been met at the time of their initial application.

13.5(3) Applicants from foreign institutions. An applicant for initial licensure whose preparation was completed in a foreign institution must additionally obtain a course-by-course credential evaluation report completed by one of the board-approved credential evaluation services and then file this report with the Iowa board of educational examiners for a determination of eligibility for licensure. After receiving the notification of eligibility by the Iowa board of educational examiners, the applicant must provide verification of successfully passing the Iowa-mandated assessment(s) pursuant to subparagraph 13.5(2) "b"(2).

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2584C, IAB 6/22/16, effective 7/27/16; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5321C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—13.6(272) Specific requirements for an initial license. An initial license valid for a minimum of two years with an expiration date of June 30 may be issued to an applicant who meets the general requirements set forth in rule 282—13.5(272).

13.6(1) For an applicant applying pursuant to subrule 13.5(1), a nonrenewable temporary initial license may be issued if the applicant presents an assessment waiver issued by the director of the Iowa department of education within 30 days of the waiver issuance. The applicant must meet the assessment requirement in order to apply for full Iowa licensure.

13.6(2) For an applicant applying pursuant to subrule 13.5(2), a nonrenewable temporary initial license may be issued to the applicant if all requirements have been met with the exception of the assessments pursuant to subparagraph 13.5(2) "b"(2). The applicant must meet the assessment requirement in order to apply for full Iowa licensure.

13.6(3) The temporary initial license shall be valid for one year from the date of issuance. This license is nonrenewable and may not be extended. This license may only be issued if the applicant

provides an affidavit from the administrator of an Iowa school district or accredited nonpublic school verifying that an offer of a teaching contract has been made and that the employer made every reasonable and good-faith effort to employ a fully licensed teacher for the specified subject and was unable to employ such a teacher.

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3979C, IAB 8/29/18, effective 10/3/18; ARC 4621C, IAB 8/28/19, effective 8/7/19]

282—13.7(272) Specific requirements for a standard license. A standard license valid for five years may be issued to an applicant who:

1. Meets the general requirements set forth in rule 282—13.5(272), and
2. Shows evidence of successful completion of a state-approved mentoring and induction program or mentoring through a state-approved career, leadership, and compensation framework by meeting the Iowa teaching standards as determined by a comprehensive evaluation and two years' successful teaching experience within the applicant's approved endorsement area(s). In lieu of completion of an Iowa state-approved mentoring program, the applicant must provide evidence of three years' successful teaching experience within the applicant's approved endorsement area(s) at any of the following:

- An accredited nonpublic school in this state.
- A preschool program approved by the United States Department of Health and Human Services.
- Preschool programs at school districts approved to participate in the preschool program under Iowa Code chapter 256C.
- Shared visions programs receiving grants from the child development coordinating council under Iowa Code section 256A.3.
- Preschool programs receiving moneys from the school ready children grants account of the early childhood Iowa fund created in Iowa Code section 256I.11.
- An out-of-state PK-12 educational setting.

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2792C, IAB 11/9/16, effective 12/14/16; ARC 3634C, IAB 2/14/18, effective 3/21/18]

282—13.8(272) Specific requirements for a master educator's license. A master educator's license is valid for five years and may be issued to an applicant who:

1. Is the holder of or is eligible for a standard license as set out in rule 282—13.7(272), and
2. Verifies five years of successful teaching experience, and
3. Completes one of the following options:
 - Master's degree in a recognized endorsement area, or
 - Master's degree in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

[ARC 1168C, IAB 11/13/13, effective 12/18/13; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—13.9(272) Teacher intern license.

13.9(1) Authorization. The teacher intern is authorized to teach in grades 7 to 12.

13.9(2) Term. The term of the teacher intern license will be one school year. This license is nonrenewable.

13.9(3) Teacher intern requirements. A teacher intern license may be issued to an applicant who has been recommended by an institution with a state-approved intern program and who has met the background check requirements set forth in rule 282—13.1(272).

13.9(4) Requirements to convert the teacher intern license to the initial license. An initial license shall be issued upon application provided that the teacher intern has met the requirements as verified by the recommendation from the state-approved program.

13.9(5) Requirements to extend the teacher intern license if the teacher intern does not complete all of the education coursework during the term of the teacher intern license.

a. A one-year extension of the teacher intern license may be issued upon application provided that the teacher intern has met both of the following requirements:

- (1) Successful completion of one year of teaching experience during the teacher internship.

(2) Verification by the recommending official at the approved teacher intern program that the teacher intern has not completed all of the coursework required for the initial license.

b. Only one year of teaching experience during the term of the teacher intern license or the extension of a teacher intern license may be used to convert the teacher intern license to a standard teaching license.

[ARC 8688B, IAB 4/7/10, effective 5/12/10; ARC 9925B, IAB 12/14/11, effective 1/18/12; ARC 0698C, IAB 5/1/13, effective 6/5/13; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1374C, IAB 3/19/14, effective 4/23/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.10(272) Specific requirements for a Class A extension license. A nonrenewable Class A extension license valid for one year may be issued to an individual under one of the following conditions:

13.10(1) *Based on an expired Iowa certificate or license, exclusive of a Class A extension or Class B license.*

a. The holder of an expired license, exclusive of a Class A extension or Class B license, shall be eligible to receive a Class A extension license upon application. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

b. The holder of an expired license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the license held shall be required to secure the signature of the superintendent or designee before the license will be issued.

13.10(2) *Based on a mentoring and induction program.* An applicant may be eligible for a Class A extension license if the school district, after conducting a comprehensive evaluation, recommends and verifies that the applicant shall participate in the mentoring program for a third year. No further extensions are available for this type of Class A extension license.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8134B, IAB 9/9/09, effective 10/14/09; ARC 8957B, IAB 7/28/10, effective 9/1/10; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.11(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

13.11(1) *Endorsement in progress.* The individual has a valid initial, standard, master educator, permanent professional, Class A extension, exchange, or professional service license and one or more endorsements but is seeking to obtain some other endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement. A Class B license may not be issued for the driver's education endorsement.

13.11(2) *Program of study.* The college or university must outline the program of study necessary to meet the endorsement requirements for specified areas. This program of study must be attached to the application.

13.11(3) *Request for executive director decision.* If the minimum content requirements have not been met for the Class B license, a one-year executive director decision license may be issued if requested by the school district and if the school district can demonstrate that a candidate with the proper endorsement was not found after a diligent search. The executive director decision license may not be renewed and will expire on June 30 of the fiscal year in which it was issued.

13.11(4) *Expiration.* The Class B license will expire on June 30 of the fiscal year in which it was issued plus one year.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8133B, IAB 9/9/09, effective 10/14/09; ARC 9207B, IAB 11/3/10, effective 12/8/10; ARC 9573B, IAB 6/29/11, effective 8/3/11; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—13.12(272) Specific requirements for a Class C license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.13(272) Specific requirements for a Class D occupational license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.14(272) Specific requirements for a Class E emergency extension license. A nonrenewable license valid for one year may be issued to an individual as follows:

13.14(1) Expired license. Based on an expired Class A or Class B license, the holder of the expired license shall be eligible to receive a Class E emergency extension license upon application and submission of all required materials.

13.14(2) Application. The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to obtain full licensure, and registration for coursework to be completed during the term of the Class E emergency extension license. The Class E emergency extension license will be denied if the applicant has not completed any coursework during the term of the Class A or Class B license unless extenuating circumstances are verified.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.15(272) Specific requirements for a Class G license. Rescinded ARC 5321C, IAB 12/16/20, effective 1/20/21.

282—13.16(272) Specific requirements for a substitute teacher's license.

13.16(1) Substitute teacher requirements. A substitute teacher's license may be issued to an individual who has completed a teacher preparation program and been the holder of, or presently holds, or is eligible to hold, a license in Iowa.

13.16(2) Validity. A substitute license is valid for five years and for not more than 90 days of teaching in one assignment during any one school year. A school district administrator may file a written request with the board for an extension of the 90-day limit in one assignment on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

13.16(3) Authorization. The holder of a substitute license is authorized to substitute teach in any school system in any position in which a regularly licensed teacher is employed except in the driver's education classroom. In addition to the authority inherent in the initial, standard, master educator, professional administrator, regional exchange, full career and technical education authorization, full native language teaching authorization, professional service license, and permanent professional licenses and the endorsement(s) held, the holder of one of these regular licenses may substitute on the same basis as the holder of a substitute license while the regular license is in effect. The executive director may grant permission for a substitute to serve outside of a substitute's regular authority under unique circumstances.

[ARC 9205B, IAB 11/3/10, effective 12/8/10; ARC 9206B, IAB 11/3/10, effective 12/8/10; ARC 0605C, IAB 2/20/13, effective 3/27/13; ARC 1324C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 5303C, IAB 12/2/20, effective 1/6/21; ARC 5321C, IAB 12/16/20, effective 1/20/21; see Delay note at end of chapter]

282—13.17(272) Specific requirements for exchange licenses.

13.17(1) Teacher exchange license.

a. For an applicant applying under 13.5(2), a two-year nonrenewable exchange license may be issued to the applicant under any of the following conditions:

(1) The applicant has met the minimum coursework requirements for licensure but has some coursework deficiencies. Any coursework deficiencies must be completed for college credit, with the exception of human relations which may be taken for licensure renewal credit through an approved provider.

(2) The applicant submits verification that the applicant has applied for and will receive the applicant's first teaching license and is waiting for the processing or printing of a valid and current out-of-state license. The lack of a valid and current out-of-state license will be listed as a deficiency.

(3) The applicant has not met the requirement for recency set forth in 13.5(2) "b"(4).

b. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(2) International teacher exchange license.

a. A nonrenewable international exchange license may be issued to an applicant under the following conditions:

- (1) The applicant has completed a teacher education program in another country; and
- (2) The applicant is a participant in a teacher exchange program administered through the Iowa department of education, the U.S. Department of Education, or the U.S. Department of State.

b. Each exchange license shall be limited to the area(s) and level(s) of instruction as determined by an analysis of the application and the credential evaluation report.

c. This license shall not exceed one year unless the applicant can verify continued participation in the exchange program beyond one year.

d. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(3) Military exchange license.

a. *Definitions.*

“*Military service*” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).

b. *Spouses of active duty military service members applying under 13.5(2).* A three-year nonrenewable military exchange license may be issued to the applicant under the following conditions:

- (1) The applicant has completed a baccalaureate degree and a traditional state-approved teacher preparation program.
- (2) The applicant is the holder of a valid and current or an expired teaching license from another state.
- (3) The applicant provides verification of the applicant’s connection to or the applicant’s spouse’s connection to the military by providing a copy of current military orders with either a marriage license or a copy of a military ID card for the applicant’s spouse.
- (4) This license may be converted to a one-year regional exchange license upon application and payment of fees.

c. *Veterans or their spouses applying under 13.5(2).* A three-year military exchange license may be issued to an applicant who meets the requirements of 13.17(3) “b”(1) and (2). A veteran must provide a copy of the veteran’s DD 214. A spouse must provide a copy of the veteran spouse’s DD 214 and the couple’s marriage license.

d. *Spouses of active duty military service veterans, or veterans’ spouses applying under 13.5(2).* If the applicant has completed a nontraditional teacher preparation program but is not eligible for a teaching license, the applicant will be issued a substitute license, and the initial review for the portfolio review process will be completed by board staff. An applicant must provide verification of connection to the military outlined in 13.17(3) “b”(3) or 13.17(3) “c.”

e. *Military education, training, and service credit.* An applicant for the military exchange license may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting documentation to the board of educational examiners. The applicant shall identify the experience or educational requirement to which the credit would be applied if granted. The board of educational examiners shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational requirement for licensure.

[ARC 8138B, IAB 9/9/09, effective 10/14/09; ARC 8604B, IAB 3/10/10, effective 4/14/10; ARC 9072B, IAB 9/8/10, effective 10/13/10; ARC 9840B, IAB 11/2/11, effective 12/7/11; ARC 0563C, IAB 1/23/13, effective 1/1/13; ARC 0868C, IAB 7/24/13, effective 8/28/13; ARC 1166C, IAB 11/13/13, effective 12/18/13; ARC 1323C, IAB 2/19/14, effective 3/26/14; ARC 1454C, IAB 5/14/14, effective 6/18/14; ARC 1878C, IAB 2/18/15, effective 3/25/15; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 5304C, IAB 12/2/20, effective 1/6/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—13.18(272) General requirements for an original teaching subject area endorsement. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.19(272) NCATE-accredited programs. Rescinded IAB 6/17/09, effective 7/22/09.

282—13.20(272) Permanent professional certificates. Effective October 1, 1988, the permanent professional certificate will no longer be issued. Any permanent professional certificate issued prior to October 1, 1988, will continue in force with the endorsements and approvals appearing thereon, unless revoked or suspended for cause. If a permanent professional certificate is revoked and if the holder is able at a later date to overcome or remediate the reasons for the revocation, the holder may apply for the appropriate new class of license set forth in this chapter.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—13.21(272) Human relations requirements for practitioner licensure. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.22(272) Development of human relations components. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.23 to 13.25 Reserved.

282—13.26(272) Requirements for elementary endorsements.

13.26(1) Teacher—prekindergarten-kindergarten.

a. Authorization. The holder of this endorsement is authorized to teach at the prekindergarten-kindergarten level. Applicants for this endorsement must also hold the teacher—elementary classroom endorsement set forth in subrule 13.26(4) or the early childhood special education endorsement set forth in 282—subrule 14.2(1).

b. Content. Coursework must total a minimum of 18 semester hours and shall include the following:

(1) Child development and learning to include young children's characteristics and needs, with an emphasis on cognitive, language, physical, social, and emotional development, both typical and atypical, the multiple interacting influences on early development, and the creation of environments that are healthy, respectful, supportive, and challenging for each and every child.

(2) Building family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

(3) Assessment in early childhood to include child observation, documentation, and data collection, the development of appropriate goals, the benefits and uses of assessment for curriculum and instructional strategies, the use of technology when appropriate for assessment and adaptations, and building assessment partnerships with families to positively influence the development of each child.

(4) Developmentally effective approaches to include understanding how positive relationships and supportive interactions are the foundation of working with young children and families; knowing and understanding a wide array of developmentally appropriate approaches, including play and creativity, instructional strategies, and tools to connect with children and families; and reflecting on the teacher's own practice to promote positive outcomes for each child.

(5) Content knowledge to build a meaningful curriculum through the use of academic disciplines, including language and literacy, the arts (music, drama, dance, and visual arts), mathematics, science, social studies, physical activity, and health, for designing, implementing, and evaluating inquiry-based experiences that promote positive development and learning for each child.

(6) Collaboration and professionalism to include involvement in the early childhood field, knowledge about ethical and early childhood professional standards, engagement in continuous collaborative learning to inform practice, reflective and critical perspectives on early childhood education, and informed advocacy for young children and the profession.

(7) Field experiences and opportunities to observe and practice in a variety of early childhood settings, which include, at a minimum, 40 hours of observation and practice in a variety of preschool

settings such as urban, rural, socioeconomic status, cultural diversity, program types, and program sponsorship.

- (8) Historical, philosophical, and social foundations of early childhood education.
- (9) Student teaching in a prekindergarten setting as required in rule 281—79.14(256).

13.26(2) Teacher—birth through grade three, inclusive settings.

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three in inclusive settings.

b. Content.

(1) Promoting child development and learning and individual learning differences.

1. Understand the nature of child growth and development for infants and toddlers (birth through age 2), preprimary (age 3 through age 5) and primary school children (age 6 through age 8), both typical and atypical, in areas of cognition, language development, physical motor, social-emotional, mental health, aesthetics, and adaptive behavior and how these impact development and learning in the first years of life, including the etiology, characteristics, and classifications of common disabilities in infants and young children and specific implications for development and learning.

2. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity, stress, risk factors, biological and environmental factors, family strengths, and trauma influence development and learning at all stages, including pre-, peri-, and postnatal development and learning. Communicate the importance of responsive care to a child's development of identity and sense of self.

3. Use developmental knowledge to create learning environments and classroom procedures that promote positive social interaction, active engagement, high expectations for learning, mutual respect, and self-regulation through individually appropriate expectations and positive guidance techniques for each child to meet the child's optimum potential regardless of proficiency. Implement and evaluate preventative and reductive strategies to address challenging behaviors. Use motivational and instructional interventions to teach individuals with exceptionalities how to adapt to different environments. Know how to intervene safely and appropriately with individuals in crisis.

4. Use both child-initiated and teacher-facilitated instructional methods, including strategies such as small and large group projects, play, systematic instruction, group discussion and cooperative decision making. Organize space, time, materials, peers, and adults to maximize progress in natural and structured environments. Embed learning opportunities in everyday routines, relationships, activities, and places. Understand the impact of social and physical environments on development and learning.

5. Engage in intentional practices and implement learning experiences that value diversity and demonstrate understanding that bias and discrimination impact development. Understand how language, culture, and family background influence and support the learning of each child.

(2) Building family and community relationships.

1. Build family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

2. Understand diverse family and community characteristics and how language, culture, and family background influence and support children's learning, and apply that knowledge to develop, implement, and evaluate learning experience and strategies that respect and reflect the diversity of children and their families.

3. Understand how to apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities. Recognize how to adapt consistently to the expressed and observed strengths and needs of the family, including two-way communication, and how to support families' choices and priorities in the development of goals and intervention strategies.

4. Understand how to coordinate with all (caregivers, professionals, and agencies) who provide care and learning opportunities for each child by developing a community of support for children and families through interagency collaboration to include agreements, referrals, and consultation.

(3) Observing, documenting, and assessing to support young children and families.

1. Use technically sound formal and informal assessments that minimize bias and evaluation results to adapt and guide instruction. Demonstrate a range of appropriate assessment and evaluation strategies (e.g., family interview, observation, documentation, assessment instrument) to support individual strengths, interests, and needs.

2. Design curricula, assessments, and teaching and intervention strategies that align with learner and program goals, including the development of individualized family service plans (IFSPs) and individualized education plans (IEPs). Assist families in identifying resources, priorities, and concerns in relation to the child's development. Understand and utilize assessment partnerships with families and with professional colleagues to build effective learning environments. Understand the role of the families in the assessment process and support the choices they make (e.g., observer, participant). Participate as a team member to integrate assessment results in the development and implementation of individualized plans.

3. Understand and utilize observation, documentation, and other appropriate assessment tools and approaches, including the use of technology in documentation, assessment and data collection. Implement authentic assessment based on observation of spontaneous play. Demonstrate knowledge of alignment of assessment with curriculum, content standards, and local, state, and federal requirements. Assess progress in the developmental domains, play, and temperament.

4. Understand and utilize responsible assessments to promote positive outcomes for each child, including the use of assistive technology for children with disabilities. Use a variety of materials and contexts to maintain the interest of infants and young children in the assessment process.

5. Implement current educational, legal, and ethical guidelines when using assessment practices to support children's individual strengths, interests, and needs (e.g., cultural, linguistic, ability diversity).

- (4) Using developmentally and individually effective approaches to connect with children and families.

1. Understand positive relationships and supportive interactions as the foundation of the teacher's work with young children. Reflect on the teacher's own practice to promote positive outcomes for each child and family.

2. Develop, implement, and evaluate individualized plans, including IFSPs and IEPs, as a team leader with families and other professionals. Demonstrate appropriate and effective supports for children and families transitioning into and out of programs or classrooms. Seek and use additional resources and agencies outside the program/school when needed to effectively facilitate the learning and social/emotional development of each child.

3. Plan, develop, implement, and evaluate integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children, their families, and other care providers based on knowledge of individual children, the family, and the community. Select, develop, and evaluate developmentally and functionally appropriate materials, equipment, and environments. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs. Use a broad repertoire of developmentally and individually appropriate teaching/learning approaches and effective strategies and tools for early education, including appropriate uses of technology. Facilitate child-initiated development and learning.

4. Consider an individual's abilities, interests, learning environments, and cultural and linguistic factors in the selection, development, and adaptation of learning experiences for individuals with exceptionalities. Use teacher-scaffolded and -initiated instruction to complement child-initiated learning. Link development, learning experiences, and instruction to promote educational transitions. Use individual and group guidance and problem-solving techniques to develop supportive relationships with and among children. Use strategies to teach social skills and conflict resolution.

5. Implement basic health, nutrition, and safety management procedures, including the design of physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

6. Understand principles of administration, organization, and operation of programs for children from birth to age 8 and their families, including staff and program development, supervision, evaluation of staff, and continuing improvement of programs and services. Employ adult learning principles in consulting with and training family members and service providers.

7. Demonstrate the ability to collaborate with general educators and other colleagues to create safe, inclusive, culturally responsive learning environments to engage individuals with exceptionalities and diverse abilities in meaningful learning activities and social interactions.

(5) Using content knowledge to build a meaningful curriculum.

1. Develop and implement appropriate current research-supported learning experiences with a focus on the developmental domains, play, temperament, language and literacy to include first (home) and second language acquisition, mathematics, science, the arts (music, visual art, and drama), physical activity, health and safety, social studies, social skills, higher-thinking skills, and developmentally and individually appropriate methodology. Methods courses are required for the following areas: literacy, mathematics, social studies, science, physical education and wellness, and visual and performing arts.

2. Use the Iowa Early Learning Standards and the Iowa core with information from ongoing child observations and assessments to plan, implement, and evaluate appropriate instruction that improves academic and developmental progress of each child, including those with IFSPs/IEPs.

3. Understand the central concepts, structures of the discipline, and tools of inquiry of content areas taught, and demonstrate the ability to organize this knowledge, integrate cross-disciplinary skills, and develop meaningful learning progressions for individuals with exceptionalities (diverse abilities).

4. Modify general and specialized curricula to make them accessible to individuals with exceptionalities (diverse abilities). Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

(6) Professional responsibilities.

1. Demonstrate awareness of early childhood program criteria, including the following: National Association for the Education of Young Children (NAEYC), Iowa Early Learning Standards, Head Start Performance Standards, and Iowa Quality Preschool Program Standards (IQPPS).

2. Collaborate with supervisors, mentors, and colleagues to enhance professional growth within and across disciplines to inform practice, including the use of data for decision making, and understand how to design and implement a professional development plan based on student achievement, self, peer, and supervisory evaluations and recommended practices.

3. Understand the significance of lifelong learning and participate in professional activities and learning communities. Participate in activities of professional organizations relevant to early childhood regular education, special education, and early intervention.

4. Use relevant national and state professional guidelines (national, state, or local), state curriculum standards, and current trends for content and outcomes and to inform and improve practices for young children and their families.

5. Adhere to state and national professional and ethical principles, practices, and codes.

6. Advocate for developmentally and individually appropriate practice, demonstrate awareness of issues that affect the lives of each child, and demonstrate necessary communication skills.

7. Understand historical, philosophical and foundational knowledge and how current issues and the legal bases of services influence professional practice in early childhood, early intervention, early childhood special education, and general and regular education in the K-3 age groups. Understand trends and issues in early childhood education, early childhood special education, and early intervention.

8. Provide guidance and direction to paraeducators, tutors, and volunteers.

(7) Early childhood field experiences.

1. Pre-student teaching field experiences, which must comprise a minimum of 100 clock hours, to include at least 20 hours of working with each age group (infants and toddlers, preprimary, and primary).

2. Experiences working in at least three settings that offer early childhood education, such as approved child care centers and registered child development homes, school-based preschool, community agencies, or home visiting programs.

3. Experiences working with children who have a range of abilities and disabilities and who reflect diverse family systems and other differentiating factors, such as urban and rural, socioeconomic status, and cultural and linguistic diversity.

4. Completion of supervised student teaching experience in at least two different settings including registered child development homes, home visiting programs, state-accredited child care centers, or classrooms which include both children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

13.26(3) *Teacher—prekindergarten through grade three, including special education.* Rescinded IAB 7/5/17, effective 8/9/17.

13.26(4) *Teacher—elementary classroom.*

a. *Authorization.* The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

b. *Content.*

(1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) At least 9 semester hours in literacy development, which must include:

1. Content:

- Oral and written communication development; and linguistics, including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics, and the relationship of these components to typical and atypical reading development and reading instruction;

- Phonemic awareness;

- Word identification, including phonics and orthography;

- Fluency;

- Vocabulary;

- Comprehension;

- Writing mechanics;

- Writing conventions;

- Writing process;

- Children's literature.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in literacy, including the knowledge of the signs and symptoms of dyslexia and other reading difficulties;

- Integration of the language arts (to include reading, writing, speaking, viewing, and listening);

- Integration of technology in teaching and student learning in literacy;

- Current best-practice, research-based strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, groupings, remediation, assistive technology, and classroom accommodations for all students including students with dyslexia and other difficulties;

- Classroom management as it applies to literacy methods;

- Pre-student teaching clinical experience in teaching literacy.

(3) At least 9 semester hours in mathematics which must include:

1. Content:

- Numbers and operations;

- Algebra/number patterns;

- Geometry;

- Measurement;

- Data analysis/probability.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in mathematics;

- Current best-practice, research-based instructional methods in mathematical processes (to include problem solving; reasoning; communication; the ability to recognize, make and apply

connections; integration of manipulatives; the ability to construct and to apply multiple connected representations; and the application of content to real world experiences);

- Integration of technology in teaching and student learning in mathematics;
- Classroom management as it applies to mathematics methods;
- Pre-student teaching clinical experience in teaching mathematics.

(4) At least 9 semester hours in social sciences which must include:

1. Content:

- History;
- Geography;
- Political science/civic literacy;
- Economics;
- Behavioral sciences.

2. Methods:

- Current best-practice, research-based approaches to the teaching and learning of social sciences;
- Integration of technology in teaching and student learning in social sciences;
- Classroom management as it applies to social science methods.

(5) At least 9 semester hours in science which must include:

1. Content:

- Physical science;
- Earth/space science;
- Life science.

2. Methods:

● Current best-practice, research-based methods of inquiry-based teaching and learning of science;

- Integration of technology in teaching and student learning in science;
- Classroom management as it applies to science methods.

(6) At least 3 semester hours to include all of the following:

1. Methods of teaching elementary physical education, health, and wellness;
2. Methods of teaching visual arts for the elementary classroom;
3. Methods of teaching performance arts for the elementary classroom.

(7) Pre-student teaching field experience in at least two different grade levels to include one primary and one intermediate placement.

(8) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.

(9) Student teaching in an elementary general education classroom.

[ARC 8400B, IAB 12/16/09, effective 1/20/10; ARC 8401B, IAB 12/16/09, effective 1/20/10; ARC 8402B, IAB 12/16/09, effective 1/20/10; ARC 8607B, IAB 3/10/10, effective 4/14/10; ARC 0446C, IAB 11/14/12, effective 12/19/12; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2527C, IAB 5/11/16, effective 6/15/16; ARC 2584C, IAB 6/22/16, effective 7/27/16; ARC 3197C, IAB 7/5/17, effective 8/9/17]

282—13.27(272) Requirements for middle school endorsements.

13.27(1) Authorization. The holder of this endorsement is authorized to teach in the two concentration areas in which the specific requirements have been completed as well as in other subject areas in grades five through eight which are not the core content areas. The holder is not authorized to teach art, industrial arts, music, reading, physical education, talented and gifted, English as a second language, and special education.

13.27(2) Program requirements.

a. Be the holder of a currently valid Iowa teacher's license with either the general elementary endorsement or one of the subject matter secondary level endorsements set out in rule 282—13.28(272).

b. A minimum of 9 semester hours of required coursework in the following:

(1) Coursework in the growth and development of the middle school age child, specifically addressing the social, emotional, physical and cognitive characteristics and needs of middle school age children in addition to related studies completed as part of the professional education core.

(2) Coursework in middle school design, curriculum, instruction, and assessment including, but not limited to, interdisciplinary instruction, teaming, and differentiated instruction in addition to related studies completed as part of the professional education core.

(3) Coursework to prepare middle school teachers in literacy (reading, writing, listening and speaking) strategies for students in grades five through eight and in methods to include these strategies throughout the curriculum.

c. Thirty hours of middle school field experiences included in the coursework requirements listed in 13.27(2)“b”(1) to (3).

13.27(3) Concentration areas. To obtain this endorsement, the applicant must complete the coursework requirements in two of the following content areas:

a. *Social studies concentration.* The social studies concentration requires 12 semester hours of coursework in social studies to include coursework in United States history, world history, government and geography.

b. *Mathematics concentration.* The mathematics concentration requires 12 semester hours in mathematics to include coursework in algebra.

c. *Science concentration.* The science concentration requires 12 semester hours in science to include coursework in life science, earth science, and physical science.

d. *Language arts concentration.* The language arts concentration requires 12 semester hours in language arts to include coursework in composition, language usage, speech, young adult literature, and literature across cultures.

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.28(272) Minimum content requirements for teaching endorsements.

13.28(1) Agriculture. 5-12. Completion of 24 semester credit hours in agriculture and agriculture education to include:

- a. Foundations of vocational and career education.
- b. Planning and implementing courses and curriculum.
- c. Methods and techniques of instruction to include evaluation of programs and students.
- d. Coordination of cooperative education programs.
- e. Coursework in each of the following areas and at least three semester credit hours in five of the following areas:

- (1) Agribusiness systems.
- (2) Power, structural, and technical systems.
- (3) Plant systems.
- (4) Animal systems.
- (5) Natural resources systems.
- (6) Environmental service systems.
- (7) Food products and processing systems.

13.28(2) Art. K-8 or 5-12. Completion of 24 semester hours in art to include coursework in art history, studio art, and two- and three-dimensional art.

13.28(3) Business—all. 5-12. Completion of 30 semester hours in business to include 6 semester hours in accounting, 3 semester hours in business law to include contract law, 3 semester hours in computer and technical applications in business, 6 semester hours in marketing to include consumer studies, 3 semester hours in management, 6 semester hours in economics, and 3 semester hours in business communications to include formatting, language usage, and oral presentation. Coursework in entrepreneurship and in financial literacy may be a part of, or in addition to, the coursework listed above.

13.28(4) Driver education. 5-12. Completion of 9 semester hours in driver education to include coursework in accident prevention that includes drug and alcohol abuse; vehicle safety; and behind-the-wheel driving.

13.28(5) English/language arts.

a. K-8. Completion of 24 semester hours in English and language arts to include coursework in oral communication, written communication, language development, reading, children's literature, creative drama or oral interpretation of literature, and American literature.

b. 5-12. Completion of 24 semester hours in English to include coursework in oral communication, written communication, language development, reading, American literature, English literature and adolescent literature.

13.28(6) Language arts. 5-12. Completion of 40 semester hours in language arts to include coursework in the following areas:

a. *Written communication.*

(1) Develops a wide range of strategies and appropriately uses writing process elements (e.g., brainstorming, free-writing, first draft, group response, continued drafting, editing, and self-reflection) to communicate with different audiences for a variety of purposes.

(2) Develops knowledge of language structure (e.g., grammar), language conventions (e.g., spelling and punctuation), media techniques, figurative language and genre to create, critique, and discuss print and nonprint texts.

b. *Oral communication.*

(1) Understands oral language, listening, and nonverbal communication skills; knows how to analyze communication interactions; and applies related knowledge and skills to teach students to become competent communicators in varied contexts.

(2) Understands the communication process and related theories, knows the purpose and function of communication and understands how to apply this knowledge to teach students to make appropriate and effective choices as senders and receivers of messages in varied contexts.

c. *Language development.*

(1) Understands inclusive and appropriate language, patterns and dialects across cultures, ethnic groups, geographic regions and social roles.

(2) Develops strategies to improve competency in the English language arts and understanding of content across the curriculum for students whose first language is not English.

d. *Young adult literature, American literature, and world literature.*

(1) Reads, comprehends, and analyzes a wide range of texts to build an understanding of self as well as the cultures of the United States and the world in order to acquire new information, to respond to the needs and demands of society and the workplace, and for personal fulfillment. Among these texts are fiction and nonfiction, graphic novels, classic and contemporary works, young adult literature, and nonprint texts.

(2) Reads a wide range of literature from many periods in many genres to build an understanding of the many dimensions (e.g., philosophical, ethical, aesthetic) of human experience.

(3) Applies a wide range of strategies to comprehend, interpret, evaluate, and appreciate texts. Draws on prior experience, interactions with other readers and writers, knowledge of word meaning and of other texts, word identification strategies, and an understanding of textual features (e.g., sound-letter correspondence, sentence structure, context, graphics).

(4) Participates as a knowledgeable, reflective, creative, and critical member of a variety of literacy communities.

e. *Creative voice.*

(1) Understands the art of oral interpretation and how to provide opportunities for students to develop and apply oral interpretation skills in individual and group performances for a variety of audiences, purposes and occasions.

(2) Understands the basic skills of theatre production including acting, stage movement, and basic stage design.

f. *Argumentation/debate.*

(1) Understands concepts and principles of classical and contemporary rhetoric and is able to plan, prepare, organize, deliver and evaluate speeches and presentations.

(2) Understands argumentation and debate and how to provide students with opportunities to apply skills and strategies for argumentation and debate in a variety of formats and contexts.

g. Journalism.

(1) Understands ethical standards and major legal issues including First Amendment rights and responsibilities relevant to varied communication content. Utilizes strategies to teach students about the importance of freedom of speech in a democratic society and the rights and responsibilities of communicators.

(2) Understands the writing process as it relates to journalism (e.g., brainstorming, questioning, reporting, gathering and synthesizing information, writing, editing, and evaluating the final media product).

(3) Understands a variety of forms of journalistic writing (e.g., news, sports, features, opinion, Web-based) and the appropriate styles (e.g., Associated Press, multiple sources with attribution, punctuation) and additional forms unique to journalism (e.g., headlines, cutlines, and/or visual presentations).

h. Mass media production.

(1) Understands the role of the media in a democracy and the importance of preserving that role.

(2) Understands how to interpret and analyze various types of mass media messages in order for students to become critical consumers.

(3) Develops the technological skills needed to package media products effectively using various forms of journalistic design with a range of visual and auditory methods.

i. Reading strategies (if not completed as part of the professional education core requirements).

(1) Uses a variety of skills and strategies to comprehend and interpret complex fiction, nonfiction and informational text.

(2) Reads for a variety of purposes and across content areas.

13.28(7) World language. K-8 and 5-12. Completion of 24 semester hours in each world language for which endorsement is sought.

13.28(8) Health. K-8 and 5-12. Completion of 24 semester hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

For holders of physical education or family and consumer science endorsements, completion of 18 credit hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(9) Family and consumer sciences—general. 5-12. Completion of 24 semester hours in family and consumer sciences to include coursework in lifespan development, parenting and child development education, family studies, consumer resource management, textiles or apparel design and merchandising, housing, foods and nutrition, and foundations of career and technical education as related to family and consumer sciences.

13.28(10) Industrial technology. 5-12. Completion of 24 semester hours in industrial technology to include coursework in manufacturing, construction, energy and power, graphic communications and transportation. The coursework is to include at least 6 semester hours in three different areas.

13.28(11) Journalism. 5-12. Completion of 15 semester hours in journalism to include coursework in writing, editing, production and visual communications.

13.28(12) Mathematics.

a. K-8. Completion of 24 semester hours in mathematics to include coursework in algebra, geometry, number theory, measurement, computer programming, and probability and statistics.

b. 5-12.

(1) Completion of 24 semester hours in mathematics to include a linear algebra or an abstract (modern) algebra course, a geometry course, a two-course sequence in calculus, a computer programming course, a probability and statistics course, and coursework in discrete mathematics.

(2) For holders of the physics 5-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

(3) For holders of the all science 9-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

c. 5-8 algebra for high school credit. For a 5-8 algebra for high school credit endorsement, hold either the K-8 mathematics or middle school mathematics endorsement and complete a college algebra or linear algebra class. This endorsement allows the holder to teach algebra to grades 5-8 for high school credit.

13.28(13) Music.

a. K-8. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history, and applied music, and a methods course in each of the following: general, choral, and instrumental music.

b. 5-12. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history (at least two courses), applied music, and conducting, and a methods course in each of the following: general, choral, and instrumental music.

13.28(14) Physical education.

a. K-8. Completion of 24 semester hours in physical education to include coursework in human anatomy, human physiology, movement education, adaptive physical education, personal wellness, human growth and development of children related to physical education, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

b. 5-12. Completion of 24 semester hours in physical education to include coursework in human anatomy, kinesiology, human physiology, human growth and development related to maturational and motor learning, adaptive physical education, curriculum and administration of physical education, personal wellness, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(15) Reading. K-8 and 5-12. Completion of 24 semester hours in reading to include all of the following requirements:

a. Foundations of reading. This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of the psychological, sociocultural, motivational, and linguistic foundations of reading and writing processes and instruction.

(2) The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including the analysis of scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice and also definitions of reading difficulties including but not limited to dyslexia.

(3) The practitioner demonstrates knowledge of the major components of reading, such as comprehension, vocabulary, word identification, fluency, phonics, and phonemic awareness, and effectively integrates curricular standards with student interests, motivation, and background knowledge.

b. Reading curriculum and instruction. This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of designing and implementing an integrated, comprehensive, and balanced curriculum that addresses the major components of reading and contains a wide range of texts, including but not limited to narrative, expository, and poetry, and including traditional print, digital, and online resources.

(2) The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties.

(3) The practitioner demonstrates knowledge of grouping students, selecting materials appropriate for learners with diverse abilities at various stages of reading and writing development, differentiating instruction to meet the unique needs of all learners, including students with dyslexia, offering sufficient opportunities for students to practice reading skills, and providing frequent and specific instructional feedback to guide students' learning.

(4) The practitioner demonstrates knowledge of designing instruction to meet the needs of diverse populations, including populations in urban, suburban, and rural settings, as well as for students from various cultural and linguistic backgrounds.

(5) The practitioner demonstrates knowledge of creating a literate physical environment which is low risk, supports students as agents of their own learning, and supports a positive socio-emotional impact for students to identify as readers.

c. Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

(1) The practitioner understands types of reading and writing assessments and their purposes, strengths, and limitations.

(2) The practitioner demonstrates knowledge of selecting and developing appropriate assessment instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification, screening, and diagnosis of all students' reading proficiencies and needs including knowledge of the signs and symptoms of dyslexia and other reading difficulties.

(3) The practitioner demonstrates knowledge of assessment data analysis to inform, plan, measure, progress monitor, and revise instruction for all students and to communicate the outcomes of ongoing assessments to all stakeholders.

(4) The practitioner demonstrates awareness of policies and procedures related to special programs, including Title I.

d. Reading in the content areas. This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of morphology and the etymology of words, along with text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

(2) The practitioner demonstrates an understanding of reading theory, reading knowledge, and a variety of research-based strategies and approaches to provide effective literacy instruction into content areas.

(3) The practitioner demonstrates knowledge of integrating literacy instruction into content areas for all students, including but not limited to students with disabilities, students who are at risk of academic failure, students who have been identified as gifted and talented, students who have limited English language proficiency, and students with dyslexia, whether or not such students have been identified as children requiring special education under Iowa Code chapter 256B.

e. Language development. This requirement includes the following competency: The practitioner uses knowledge of oral language development, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, cognitive academic language development, oral and written language proficiency (including second language development), acquisition of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

f. Oral communication instruction. This requirement includes the following competencies:

(1) The practitioner has knowledge of the unique needs and backgrounds of students with language differences and delays.

(2) The practitioner uses effective strategies for facilitating the learning of language for academic purposes by all learners.

g. Written communication instruction. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process to include structures of language and grammar; the stages of spelling development; the different types of writing, such as narrative, expressive, persuasive, informational, and descriptive; and the connections between oral and written language development to effectively teach writing as communication.

h. Children's fiction and nonfiction (K-8 only) or adolescent or young adult fiction and nonfiction (5-12 only). This requirement includes the following competency: The practitioner uses knowledge of children's literature (K-8) or adolescent or young adult literature (5-12) for:

(1) Modeling the reading and writing of varied genres, including fiction and nonfiction; technology- and media-based information; and nonprint materials;

(2) Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds, and perspectives; and

(3) Matching text complexities to the proficiencies and needs of readers.

i. Practicum. This requirement includes the following competencies:

(1) The practitioner works with appropriately licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

(2) The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research and works with colleagues and families in the support of children's reading and writing development.

13.28(16) Reading specialist. K-12. The applicant must have met the requirements for the standard license and a K-8 or 5-12 reading endorsement and must present evidence of at least three years of experience which included the teaching of reading as a significant part of the responsibility.

a. Authorization. The holder of this endorsement is authorized to serve as a reading specialist in kindergarten and grades one through twelve.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. This sequence is to be at least 24 semester hours to include the following:

(1) Foundations of reading. The reading specialist will understand the historical, theoretical, and evidence-based foundations of reading and writing processes and instruction and will be able to interpret these findings to model exemplary instructional methods for students with typical and atypical literacy development and effectively develop and lead professional development.

(2) Curriculum and instruction. The reading specialist will use instructional approaches, materials, and an integrated, comprehensive, balanced curriculum to support student learning in reading and writing including the following:

1. Work collaboratively with teachers to develop a literacy curriculum that has vertical and horizontal alignment K-12 and that uses instructional approaches supported by literature and research for the following areas: print, phonemic awareness, phonics, fluency, comprehension, vocabulary, writing, critical thinking, and motivation.

2. Support classroom teachers to implement and adapt in-depth instructional approaches, including but not limited to approaches to improve decoding, comprehension, and information retention, to meet the language-proficiency needs of English language learners and the needs of students with reading difficulties or reading disabilities, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties within or outside the regular classroom.

3. Demonstrate a knowledge of a wide variety of quality traditional print, digital, and online resources and support classroom teachers in building and using a quality, accessible classroom library and materials collection that meets the specific needs and abilities of all learners.

4. Provide support for curriculum and instruction through modeling, coteaching, observing, planning, reviewing literacy data, and providing resources.

(3) Assessment, diagnosis, and evaluation. The reading specialist will use a variety of assessment tools and practices to plan and evaluate effective reading and writing instruction including the following:

1. Demonstrate an understanding of the literature and research related to assessments and their purposes, including the strengths and limitations of assessments, and assessment tools for screening, diagnosis, progress monitoring, and measuring outcomes; demonstrate an understanding of the signs and symptoms of reading difficulties including but not limited to dyslexia; and also demonstrate an understanding of district and state assessments, proficiency standards and student benchmarks.

2. Select, administer, and interpret assessments for specific purposes, including collaboration with teachers in the analysis of data, and leading schoolwide or districtwide scale analyses to select assessment

tools that provide a systemic framework for assessing reading, writing, and language growth of all students, including those with reading difficulties and reading disabilities including but not limited to students with dyslexia and English language learners.

3. Use assessment information to plan and evaluate instruction, including multiple data sources for analysis and instructional planning, for examining the effectiveness of specific intervention practices and students' responses to interventions including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties, and to plan professional development initiatives.

4. Communicate assessment results and implications to a variety of audiences.

(4) Administration and supervision of reading programs. The reading specialist will:

1. Demonstrate foundational knowledge of adult learning theories and related research about organizational change, professional development, and school culture.

2. Demonstrate the practical application of literacy leadership including planning, developing, supervising, and evaluating literacy programs at all levels.

3. Demonstrate knowledge of supervising an overall reading program, including but not limited to staffing; budgetary practices; planning, preparing, and selecting materials; subsystems; special provisions; and evaluating teacher performance.

4. Participate in, design, facilitate, lead, and evaluate effective and differentiated professional development programs to effectively implement literacy instruction.

5. Demonstrate an understanding of local, state, and national policies that affect reading and writing instruction.

6. Promote effective communication and collaboration among stakeholders, including parents and guardians, teachers, administrators, policymakers, and community members, and advocate for change when necessary to promote effective literacy instruction.

(5) Educational research, measurement and evaluation. The reading specialist will effectively utilize existing research and learn to conduct new research to continuously improve the design and implementation of a comprehensive reading system.

(6) Psychology of language and reading. The reading specialist will understand the highly complex processes by which children learn to speak, read, and write, including language acquisition, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, ranges of individual differences, reading difficulties and reading disabilities, including but not limited to dyslexia, and the importance of the role of diversity in learning to read and write.

(7) Practicum in reading leadership. The reading specialist will participate in elementary and secondary practicum experiences with licensed teachers who are serving in leadership roles in the area of reading.

13.28(17) Science.

a. Science—basic. K-8.

(1) Required coursework. Completion of at least 24 semester hours in science to include 12 hours in physical sciences, 6 hours in biology, and 6 hours in earth/space sciences.

(2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.

4. Be able to use scientific understanding when dealing with personal and societal issues.

b. Biological science. 5-12. Completion of 24 semester hours in biological science or 30 semester hours in the broad area of science to include 15 semester hours in biological science.

c. Chemistry. 5-12. Completion of 24 semester hours in chemistry or 30 semester hours in the broad area of science to include 15 semester hours in chemistry.

d. Earth science. 5-12. Completion of 24 semester hours in earth science or 30 semester hours in the broad area of science to include 15 semester hours in earth science.

e. Basic science. 5-12. Completion of 24 semester hours of credit in science to include the following:

(1) Six semester hours of credit in earth and space science to include the following essential concepts and skills:

1. Understand and apply knowledge of energy in the earth system.
2. Understand and apply knowledge of geochemical cycles.

(2) Six semester hours of credit in life science/biological science to include the following essential concepts and skills:

1. Understand and apply knowledge of the cell.
2. Understand and apply knowledge of the molecular basis of heredity.
3. Understand and apply knowledge of the interdependence of organisms.
4. Understand and apply knowledge of matter, energy, and organization in living systems.
5. Understand and apply knowledge of the behavior of organisms.

(3) Six semester hours of credit in physics/physical science to include the following essential concepts and skills:

1. Understand and apply knowledge of the structure of atoms.
2. Understand and apply knowledge of the structure and properties of matter.
3. Understand and apply knowledge of motions and forces.
4. Understand and apply knowledge of interactions of energy and matter.

(4) Six semester hours of credit in chemistry to include the following essential concepts and skills:

1. Understand and apply knowledge of chemical reactions.
2. Be able to design and conduct scientific investigations.

f. Physical science. Rescinded IAB 11/14/12, effective 12/19/12.

g. Physics.

(1) 5-12. Completion of 24 semester hours in physics or 30 semester hours in the broad area of science to include 15 semester hours in physics.

(2) For holders of the mathematics 5-12 endorsement, completion of:

1. 12 credits of physics to include coursework in mechanics, electricity, and magnetism; and
2. A methods class that includes inquiry-based instruction, resource management, and laboratory safety.

(3) For holders of the chemistry 5-12 endorsement, completion of 12 credits of physics to include coursework in mechanics, electricity, and magnetism.

h. All science I. Rescinded IAB 11/14/12, effective 12/19/12.

i. All science. 5-12.

(1) Completion of 36 semester hours of credit in science to include the following:

1. Nine semester hours of credit in earth and space science to include the following essential concepts and skills:

- Understand and apply knowledge of energy in the earth system.
- Understand and apply knowledge of geochemical cycles.
- Understand and apply knowledge of the origin and evolution of the earth system.
- Understand and apply knowledge of the origin and evolution of the universe.

2. Nine semester hours of credit in life science/biological science to include the following essential concepts and skills:

- Understand and apply knowledge of the cell.
- Understand and apply knowledge of the molecular basis of heredity.
- Understand and apply knowledge of the interdependence of organisms.
- Understand and apply knowledge of matter, energy, and organization in living systems.
- Understand and apply knowledge of the behavior of organisms.
- Understand and apply knowledge of biological evolution.

3. Nine semester hours of credit in physics/physical science to include the following essential concepts and skills:

- Understand and apply knowledge of the structure of atoms.
- Understand and apply knowledge of the structure and properties of matter.
- Understand and apply knowledge of motions and forces.
- Understand and apply knowledge of interactions of energy and matter.
- Understand and apply knowledge of conservation of energy and increase in disorder.

4. Nine semester hours of credit in chemistry to include the following essential concepts and skills:

- Understand and apply knowledge of chemical reactions.
- Be able to design and conduct scientific investigations.

(2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.

4. Be able to use scientific understanding when dealing with personal and societal issues.

13.28(18) Social sciences.

a. *American government.* 5-12. Completion of 24 semester hours in American government or 30 semester hours in the broad area of social sciences to include 15 semester hours in American government.

b. *American history.* 5-12. Completion of 24 semester hours in American history or 30 semester hours in the broad area of social sciences to include 15 semester hours in American history.

c. *Anthropology.* 5-12. Completion of 24 semester hours in anthropology or 30 semester hours in the broad area of social sciences to include 15 semester hours in anthropology.

d. *Economics.* 5-12. Completion of 24 semester hours in economics or 30 semester hours in the broad area of social sciences to include 15 semester hours in economics, or 30 semester hours in the broad area of business to include 15 semester hours in economics.

e. *Geography.* 5-12. Completion of 24 semester hours in geography or 30 semester hours in the broad area of social sciences to include 15 semester hours in geography.

f. *History.* K-8. Completion of 24 semester hours in history to include at least 9 semester hours in American history and 9 semester hours in world history.

g. *Psychology.* 5-12. Completion of 24 semester hours in psychology or 30 semester hours in the broad area of social sciences to include 15 semester hours in psychology.

h. *Social studies.* K-8. Completion of 24 semester hours in social studies, to include coursework from at least three of these areas: history, sociology, economics, American government, psychology and geography.

i. *Sociology.* 5-12. Completion of 24 semester hours in sociology or 30 semester hours in the broad area of social sciences to include 15 semester hours in sociology.

j. *World history.* 5-12. Completion of 24 semester hours in world history or 30 semester hours in the broad area of social sciences to include 15 semester hours in world history.

k. *All social sciences.* 5-12. Completion of 51 semester hours in the social sciences to include 9 semester hours in each of American and world history, 9 semester hours in government, 6 semester hours in sociology, 6 semester hours in psychology other than educational psychology, 6 semester hours in geography, and 6 semester hours in economics.

l. *Social sciences—basic.* 5-12. Completion of 27 semester hours to include 9 semester hours in each of American history, world history, and American government. Holders of the 5-12 social sciences—basic endorsement may add the following endorsements with 6 semester hours per endorsement area: 5-12 economics, 5-12 geography, 5-12 psychology, or 5-12 sociology.

13.28(19) Speech communication/theatre.

a. *K-8.* Completion of 20 semester hours in speech communication/theatre to include coursework in speech communication, creative drama or theatre, and oral interpretation.

b. 5-12. Completion of 24 semester hours in speech communication/theatre to include coursework in speech communication, oral interpretation, creative drama or theatre, argumentation and debate, and mass media communication.

13.28(20) English as a second language (ESL). K-12.

a. *Authorization.* The holder of this endorsement is authorized to teach English as a second language in kindergarten and grades one through twelve.

b. *Content.* Completion of 18 semester hours of coursework in English as a second language to include the following:

(1) Knowledge of pedagogy to include the following:

1. Methods and curriculum to include the following:

- Bilingual and ESL methods.
 - Literacy in native and second language.
 - Methods for subject matter content.
 - Adaptation and modification of curriculum.
2. Assessment to include language proficiency and academic content.

(2) Knowledge of linguistics to include the following:

1. Psycholinguistics and sociolinguistics.
2. Language acquisition and proficiency to include the following:
- Knowledge of first and second language proficiency.
 - Knowledge of first and second language acquisition.
 - Language to include structure and grammar of English.

(3) Knowledge of cultural and linguistic diversity to include the following:

1. History.
2. Theory, models, and research.
3. Policy and legislation.

(4) Current issues with transient populations.

13.28(21) Elementary school teacher librarian.

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade eight.

b. *Content.* Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in children.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among children, based on familiarity with selection tools and current trends in literature for children.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the elementary level.

13.28(22) *Secondary school teacher librarian.*

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in grades five through twelve.

b. *Content.* Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in young adults.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among young adults, based on familiarity with selection tools and current trends in literature for young adults.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the secondary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the secondary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the secondary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the secondary level.

13.28(23) School teacher librarian. PK-12.

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade twelve. The applicant must be the holder of or eligible for the initial license.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements. This sequence is to be at least 30 semester hours in school library coursework, to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy for youth of all ages.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading, based on familiarity with selection tools and current trends in literature for youth of all ages.

3. Practitioners understand how to develop a collection of reading and informational materials in print and digital formats that supports the diverse developmental, cultural, social and linguistic needs of all learners and their communities.

4. Practitioners model and teach reading comprehension strategies to create meaning from text for youth of all ages.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

8. Practitioners understand the process of collecting, interpreting, and using data to develop new knowledge to improve the school library program.

9. Practitioners employ the methods of research in library and information science.
- (3) Program administration and leadership. This requirement includes the following competencies:
 1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.
 2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.
 3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users of all ages.
 4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.
 5. Practitioners demonstrate knowledge of best practices related to planning, budgeting (including alternative funding), organizing, and evaluating human and information resources and facilities to ensure equitable access.
 6. Practitioners understand strategic planning to ensure that the school library program addresses the needs of diverse communities.
 7. Practitioners advocate for school library and information programs, resources, and services among stakeholders.
 8. Practitioners promote initiatives and partnerships to further the mission and goals of the school library program.
- (4) Practicum. This requirement includes the following competencies:
 1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary and secondary levels.
 2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary and secondary levels.
 3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary and secondary levels.
 4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula.

13.28(24) Talented and gifted teacher.

a. Authorization. The holder of this endorsement is authorized to serve as a teacher or a coordinator of programs for the talented and gifted from the prekindergarten level through grade twelve. This authorization does not permit general classroom teaching at any level except that level or area for which the holder is eligible or holds the specific endorsement.

b. Program requirements—content. Completion of 12 undergraduate or graduate semester hours of coursework in the area of the talented and gifted to include the following:

- (1) Psychology of the gifted.
 1. Social needs.
 2. Emotional needs.
- (2) Programming for the gifted.
 1. Prekindergarten-12 identification.
 2. Differentiation strategies.
 3. Collaborative teaching skills.
 4. Program goals and performance measures.
 5. Program evaluation.
- (3) Practicum experience in gifted programs.

NOTE: Teachers in specific subject areas will not be required to hold this endorsement if they teach gifted students in their respective endorsement areas.

13.28(25) American Sign Language endorsement.

a. Authorization. The holder of this endorsement is authorized to teach American Sign Language in kindergarten and grades one through twelve.

b. Content. Completion of 18 semester hours of coursework in American Sign Language to include the following:

- (1) Second language acquisition.
- (2) Sociology of the deaf and hard-of-hearing community.
- (3) Linguistic structure of American Sign Language.
- (4) Language teaching methodology specific to American Sign Language.
- (5) Teaching the culture of deaf and hard-of-hearing people.
- (6) Assessment of students in an American Sign Language program.

13.28(26) Elementary professional school counselor.

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include the following:

- (1) Nature and needs of individuals at all developmental levels.
 1. Develop strategies for facilitating development through the transition from childhood to adolescence and from adolescence to young adulthood.
 2. Apply knowledge of learning and personality development to assist students in developing their full potential.
- (2) Social and cultural foundations.
 1. Demonstrate awareness of and sensitivity to the unique social, cultural, and economic circumstances of students and their racial/ethnic, gender, age, physical, and learning differences.
 2. Demonstrate sensitivity to the nature and the functioning of the student within the family, school and community contexts.
 3. Demonstrate the counseling and consultation skills needed to facilitate informed and appropriate action in response to the needs of students.
- (3) Fostering of relationships.
 1. Employ effective counseling and consultation skills with students, parents, colleagues, administrators, and others.
 2. Communicate effectively with parents, colleagues, students and administrators.
 3. Counsel students in the areas of personal, social, academic, and career development.
 4. Assist families in helping their children address the personal, social, and emotional concerns and problems that may impede educational progress.
 5. Implement developmentally appropriate counseling interventions with children and adolescents.
 6. Demonstrate the ability to negotiate and move individuals and groups toward consensus or conflict resolution or both.
 7. Refer students for specialized help when appropriate.
 8. Value the well-being of the students as paramount in the counseling relationship.
- (4) Group work.
 1. Implement developmentally appropriate interventions involving group dynamics, counseling theories, group counseling methods and skills, and other group work approaches.
 2. Apply knowledge of group counseling in implementing appropriate group processes for elementary, middle school, and secondary students.
- (5) Career development, education, and postsecondary planning.
 1. Assist students in the assessment of their individual strengths, weaknesses, and differences, including those that relate to academic achievement and future plans.
 2. Apply knowledge of career assessment and career choice programs.
 3. Implement occupational and educational placement, follow-up and evaluation.
 4. Develop a counseling network and provide resources for use by students in personalizing the exploration of postsecondary educational opportunities.
- (6) Assessment and evaluation.

1. Demonstrate individual and group approaches to assessment and evaluation.
2. Demonstrate an understanding of the proper administration and uses of standardized tests.
3. Apply knowledge of test administration, scoring, and measurement concerns.
4. Apply evaluation procedures for monitoring student achievement.
5. Apply assessment information in program design and program modifications to address students' needs.
6. Apply knowledge of legal and ethical issues related to assessment and student records.
- (7) Professional orientation.
 1. Apply knowledge of history, roles, organizational structures, ethics, standards, and credentialing.
 2. Maintain a high level of professional knowledge and skills.
 3. Apply knowledge of professional and ethical standards to the practice of school counseling.
 4. Articulate the professional school counselor role to school personnel, parents, community, and students.
- (8) School counseling skills.
 1. Design, implement, and evaluate a comprehensive, developmental school counseling program.
 2. Implement and evaluate specific strategies designed to meet program goals and objectives.
 3. Consult and coordinate efforts with resource persons, specialists, businesses, and agencies outside the school to promote program objectives.
 4. Provide information appropriate to the particular educational transition and assist students in understanding the relationship that their curricular experiences and academic achievements will have on subsequent educational opportunities.
 5. Assist parents and families in order to provide a supportive environment in which students can become effective learners and achieve success in pursuit of appropriate educational goals.
 6. Provide training, orientation, and consultation assistance to faculty, administrators, staff, and school officials to assist them in responding to the social, emotional, and educational development of all students.
 7. Collaborate with teachers, administrators, and other educators in ensuring that appropriate educational experiences are provided that allow all students to achieve success.
 8. Assist in the process of identifying and addressing the needs of the exceptional student.
 9. Apply knowledge of legal and ethical issues related to child abuse and mandatory reporting.
 10. Advocate for the educational needs of students and work to ensure that these needs are addressed at every level of the school experience.
 11. Promote use of school counseling and educational and career planning activities and programs involving the total school community to provide a positive school climate.
- (9) Classroom management.
 1. Apply effective classroom management strategies as demonstrated in delivery of classroom and large group school counseling curriculum.
 2. Consult with teachers and parents about effective classroom management and behavior management strategies.
- (10) Curriculum.
 1. Write classroom lessons including objectives, learning activities, and discussion questions.
 2. Utilize various methods of evaluating what students have learned in classroom lessons.
 3. Demonstrate competency in conducting classroom and other large group activities, utilizing an effective lesson plan design, engaging students in the learning process, and employing age-appropriate classroom management strategies.
 4. Design a classroom unit of developmentally appropriate learning experiences.
 5. Demonstrate knowledge in writing standards and benchmarks for curriculum.
- (11) Learning theory.
 1. Identify and consult with teachers about how to create a positive learning environment utilizing such factors as effective classroom management strategies, building a sense of community in the classroom, and cooperative learning experiences.

2. Identify and consult with teachers regarding teaching strategies designed to motivate students using small group learning activities, experiential learning activities, student mentoring programs, and shared decision-making opportunities.

3. Demonstrate knowledge of child and adolescent development and identify developmentally appropriate teaching and learning strategies.

(12) Teaching and counseling practicum. The candidate will complete a preservice supervised practicum of a minimum of 100 hours, and at least 40 of these hours must be direct service. Candidates will complete a supervised internship for a minimum of 600 hours, and at least 240 of these hours must be direct service. For candidates seeking both the K-8 and 5-12 professional school counselor endorsements, a minimum of 100 hours of the practicum or internship experiences listed above must be completed at each of the desired endorsement levels.

13.28(27) Secondary professional school counselor.

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in grades five through twelve.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in subparagraphs 13.28(26) "c"(1) to (11).

(2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 13.28(26) "c"(12).

13.28(28) School nurse endorsement. The school nurse endorsement does not authorize general classroom teaching, although it does authorize the holder to teach health at all grade levels. Alternatively, a nurse may obtain a statement of professional recognition (SPR) from the board of educational examiners, in accordance with the provisions set out in 282—Chapter 16, Statements of Professional Recognition (SPR).

a. Authorization. The holder of this endorsement is authorized to provide service as a school nurse at the prekindergarten and kindergarten levels and in grades one through twelve.

b. Content.

(1) Organization and administration of school nurse services including the appraisal of the health needs of children and youth.

(2) School-community relationships and resources/coordination of school and community resources to serve the health needs of children and youth.

(3) Knowledge and understanding of the health needs of exceptional children.

(4) Health education.

c. Other. Hold a license as a registered nurse issued by the Iowa board of nursing.

13.28(29) Athletic coach. K-12. An applicant for the coaching endorsement must hold a teacher's license with one of the teaching endorsements.

a. Authorization. The holder of this endorsement may serve as a head coach or an assistant coach in kindergarten and grades one through twelve.

b. Program requirements.

(1) One semester hour college or university course in the structure and function of the human body in relation to physical activity, and

(2) One semester hour college or university course in human growth and development of children and youth as related to physical activity, and

(3) Two semester hour college or university course in athletic conditioning, care and prevention of injuries and first aid as related to physical activity, and

(4) One semester hour college or university course in the theory of coaching interscholastic athletics, and

(5) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union, and

(6) A current certificate of CPR training.

13.28(30) Content specialist endorsement. Rescinded IAB 12/16/20, effective 1/20/21.

13.28(31) Engineering. 5-12.

- a. Completion of 24 semester hours in engineering coursework.
- b. Methods and strategies of STEM instruction or methods of teaching science or mathematics.

13.28(32) STEM.**a. K-8.**

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in kindergarten through grade eight.

(2) Program requirements. Be the holder of the teacher—elementary classroom endorsement.

(3) Content.

1. Completion of a minimum of 12 semester hours of college-level science.

2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.

3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;

- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

b. 5-8.

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in grades five through eight.

(2) Program requirements. Be the holder of a 5-12 science, mathematics, or industrial technology endorsement or 5-8 middle school mathematics or science endorsement.

(3) Content.

1. Completion of a minimum of 12 semester hours of college-level science.

2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.

3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);

- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;

- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

c. *Specialist K-12.*

(1) Authorization. The holder of this endorsement is authorized to serve as a STEM specialist in kindergarten and grades one through twelve.

(2) Program requirements.

1. The applicant must have met the requirements for a standard Iowa teaching license and a teaching endorsement in mathematics, science, engineering, industrial technology, or agriculture.

2. The applicant must hold a master's degree in math, science, engineering or technology or another area with at least 12 hours of college-level science and at least 12 hours of college-level math (or completion of Calculus I) to include coursework in computer programming.

(3) Content.

1. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

2. Completion of 9 semester hours in professional development to include the following essential concepts and skills:

- STEM curriculum and methods:
 - Comparing and contrasting the nature and goals of each of the STEM disciplines;
 - Promoting learning through purposeful, authentic, real-world connections;
 - Integration of content and context of each of the STEM disciplines;

- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
 - Curriculum/standards mapping;
 - Assessment of integrative learning approaches;
 - Information literacy skills in STEM;
 - Processes of science/scientific inquiry;
 - Mathematical problem-solving models;
 - Classroom management in project-based classrooms;
 - Instructional strategies for the inclusive classroom;
 - Computational thinking;
 - Mathematical and technological modeling.
 - STEM experiential learning:
 - Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
 - STEM research experiences;
 - STEM internship at a STEM business or informal education organization;
 - STEM extracurricular activity;
 - Communicating to a variety of audiences.
 - Leadership in STEM:
 - STEM curriculum development and assessment;
 - Curriculum mapping;
 - Assessment of student engagement;
 - STEM across the curriculum;
 - Research on best practices in STEM;
 - STEM curriculum accessibility for all students.
3. Completion of an internship/externship professional experience or prior professional experience in STEM for a minimum of 90 contact hours.

13.28(33) Multioccupations.

a. Completion of any 5-12 endorsement and, in addition thereto, coursework in foundations of career and technical education and coordination of cooperative programs, and work experience which meets one of the following:

- (1) Four thousand hours of career and technical experience in two or more careers; or
- (2) One thousand hours of work experience or externships in two or more careers and two or more years of teaching experience at the PK-12 level.

b. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, work-based learning programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

13.28(34) CTE information technology. 5-12.

a. *Authorization.* The holder of this endorsement is authorized to teach career and technical education (CTE) information technology, CTE computer science, and CTE computer programming courses.

b. *Program requirements.* Applicants must hold a valid Iowa teaching license with at least one other teaching endorsement.

c. *Content.* A minimum of 12 semester hours of computer science to include coursework in the following:

- (1) Data representation and abstraction to include primitive data types, static and dynamic data structures, and data types and stores.
- (2) Designing, developing, testing and refining algorithms to include proficiency in two or more programming paradigms.
- (3) Systems and networks to include operating systems, networks, mobile devices, and machine-level data representation.

d. Methods course. A content area methods course is required pursuant to 13.29(1). The course should include the following effective teaching and learning strategies for information technology:

(1) Curriculum development including recognizing and defining real-world computational problems; computing concepts and constructs; developing and using abstractions; creating, testing, and refining computational artifacts; and problem-solving strategies in computer science.

(2) Project-based methodologies that support active and authentic learning, fostering an inclusive computing culture, collaborative groupings, and opportunities for creative and innovative thinking.

(3) Communication about computing including multiple forms of media.

(4) Digital citizenship including the social, legal, ethical, safe and effective use of computer hardware, software, peripherals, and networks.

e. CTE methods.

(1) A minimum of six semester hours of career and technical curriculum and methods to include:

1. Foundations of career and technical education.

2. Methods of career and technical education.

3. Evaluation and assessment of career and technical programs.

(2) The CTE methods coursework is not required if the educator holds another career and technical endorsement.

f. Waiver of coursework requirements. During the first year of implementation, the coursework requirements may be waived if the practitioner demonstrates relevant content knowledge mastery and successful teaching experience in this endorsement area through criteria established by the board of educational examiners.

13.28(35) Computer science. K-8 and 5-12.

a. Authorization. The holder of this endorsement is authorized to teach selected computer science and computer programming courses.

b. Program requirements. Applicants must hold a valid Iowa teaching license with at least one additional teaching endorsement.

c. Content. A minimum of 12 semester hours of computer science to include coursework in the following:

(1) Data representation and abstraction to include primitive data types, static and dynamic data structures, and data types and stores.

(2) Designing, developing, testing and refining algorithms to include proficiency in two or more programming paradigms.

(3) Systems and networks to include operating systems, networks, mobile devices, and machine-level data representation.

d. Methods course. A content area methods course is required pursuant to 13.29(1). The course should include the following effective teaching and learning strategies for information technology:

(1) Curriculum development including recognizing and defining real-world computational problems; computing concepts and constructs; developing and using abstractions; creating, testing, and refining computational artifacts; and problem-solving strategies in computer science.

(2) Project-based methodologies that support active and authentic learning, fostering an inclusive computing culture, collaborative groupings, and opportunities for creative and innovative thinking.

(3) Communication about computing including multiple forms of media.

(4) Digital citizenship including the social, legal, ethical, safe and effective use of computer hardware, software, peripherals, and networks.

e. Computer science specialist. If the requirements in 13.28(35)“c” and “d” are met and the applicant achieves a minimum of 24 semester hours of computer science content, a computer science specialist endorsement will be granted and the additional teaching endorsement set forth in 13.28(35)“b” will not be required.

f. Waiver of coursework requirements. During the first year of implementation, the coursework requirements may be waived if the practitioner demonstrates relevant content knowledge mastery and successful teaching experience in this endorsement area through criteria established by the board of educational examiners.

13.28(36) Dyslexia specialist. K-12. The applicant must have met the requirements for the standard license and have completed at least three years of post-baccalaureate teaching experience in a K-12 setting. Applicants who have achieved dyslexia certification in another state prior to March 17, 2021, may apply for a certification review.

a. Authorization. The holder of this endorsement is authorized to serve as a dyslexia specialist in kindergarten and grades 1 through 12.

b. Content. Completion of 18 semester hours in dyslexia strategies to include the following:

(1) Knowledge of dyslexia. The dyslexia specialist will have knowledge of dyslexia and:

1. Understand the tenets of the International Dyslexia Association's definition of dyslexia, including the neurobiological nature and cognitive-linguistic correlates.

2. Identify distinguishing characteristics of dyslexia and commonly co-occurring disorders, including dysgraphia, dyscalculia, attention deficit hyperactivity disorder, expressive language disorders, receptive language disorders, and others.

3. Recognize that dyslexia may present differently along a continuum of severity and impact depending upon age, grade, and compensatory factors.

4. Understand federal and state laws that pertain to dyslexia, including use of the word "dyslexia" within school settings and documentation.

5. Understand common misconceptions regarding characteristics of and interventions for dyslexia.

(2) Psychology of language and reading. The dyslexia specialist will understand the highly complex processes by which children learn to speak, read, and write, including language acquisition, linguistics, and the structure of written language, including phonological processing, phonics, orthography, morphology, syntax, and semantics, as well as the relationship of these components to typical and atypical reading and writing development and instruction for students with dyslexia.

(3) Curriculum and instruction. The dyslexia specialist will use appropriate instructional approaches and materials as well as integrated, comprehensive, explicit, and systematic literacy instruction to support student learning in reading and writing, including the following:

1. Instruction utilizing multisensory and multimodal strategies (visual, auditory, kinesthetic, and tactile), systematic and cumulative instruction, direct instruction, diagnostic and prescriptive teaching, as well as synthetic and analytic instruction.

2. Instructional approaches supported by the science of reading for the following areas: phonological processing, phonics, fluency, comprehension, vocabulary, spelling, and writing.

3. Creation of a dyslexia-friendly learning environment (within or outside the regular classroom) utilizing evidence-based accommodations and modifications to meet the needs of students with dyslexia, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia.

4. Use of data to determine effectiveness of the instruction and curriculum along with student responsiveness to it.

(4) Assessment, diagnosis, and evaluation. The dyslexia specialist will be confident using a variety of formal assessment tools and practices to evaluate students' reading and writing abilities in a variety of domains. The dyslexia specialist will:

1. Demonstrate an understanding of the literature and research related to assessments and their purposes (including the strengths and limitations of assessments) and assessment tools for screening, diagnosis, progress monitoring, and measuring outcomes.

2. Demonstrate an understanding of the signs and symptoms of reading difficulties, including but not limited to dyslexia; and also demonstrate an understanding of norms and student benchmarks.

3. Select, administer, and interpret assessments for specific purposes, including screening students at risk for dyslexia and identifying students who display a profile of dyslexia, and:

- Understand the features of standardized norm-referenced assessments.

- Understand the importance of selecting reliable and valid assessments to evaluate typical and atypical reading development.

- Interpret various scores derived from standardized norm-referenced and criterion-referenced assessments.

4. Use assessment information to plan and evaluate instruction, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties. This will include the use of multiple data sources for analysis, instructional planning, examining the effectiveness of specific intervention practices, and examining students' responses to interventions.

5. Communicate assessment results and implications to a variety of audiences, including staff, parents, and students.

6. Understand appropriate IEP goals and Section 504 plans for students who display characteristics of dyslexia.

(5) Practicum in dyslexia. The dyslexia specialist will participate in elementary and secondary practicum experiences with instructors who have experience with and are currently serving students who display characteristics of dyslexia. The cooperating teacher must be approved by the Iowa reading research center. The practicum must include:

1. Supervised administration of norm-referenced literacy assessments.

2. Practice composing a report of literacy assessment results that will include interpretation of the results and instructional recommendations.

3. Supervised delivery of systematic, explicit, and multisensory intervention for students with characteristics of dyslexia.

4. Practice composing a report of students' response to intervention.

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282—13.29(272) Adding, removing or reinstating a teaching endorsement.

13.29(1) Adding an endorsement. After the issuance of a teaching license, an individual may add other endorsements to that license upon proper application, provided current requirements for that endorsement have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

a. Options. To add an endorsement, the applicant must follow one of these options:

(1) Option 1. Receive the Iowa teacher education institution's recommendation that the current approved program requirements for the endorsement have been met.

(2) Option 2. Receive verification from the Iowa teacher education institution that the minimum state requirements for the endorsement have been met in lieu of the institution's approved program.

(3) Option 3. Apply for a review of the transcripts by the board of educational examiners' staff to determine if all Iowa requirements have been met. The applicant must submit documentation that all of the Iowa requirements have been met by filing transcripts and supporting documentation for review. The fee for the transcript evaluation is in 282—Chapter 12. This fee shall be in addition to the fee for adding the endorsement.

b. Additional requirements for adding an endorsement.

(1) In addition to meeting the requirements for Iowa licensure, applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area and grade levels of the endorsement added.

(2) Practitioners who are adding a K-8 endorsement and have not student taught at the elementary level shall complete a teaching practicum in an elementary setting. Applicants seeking the early childhood or elementary endorsements set forth in rule 282—13.26(272) must complete the required field experience and teaching practicum specific to the endorsement desired.

(3) Practitioners who are adding a 5-12 endorsement and have not student taught at the secondary level shall complete a teaching practicum in a high school setting.

(4) Practitioners holding the K-8 endorsement in the content area of the 5-12 endorsement being added may satisfy the requirement for the secondary methods class and the teaching practicum by completing all required coursework and presenting verification of competence. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level. This verification of competence may be submitted at any time during the term of the Class B license. The practitioner must obtain a Class B license while practicing with the 5-12 endorsement.

(5) Applicants seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for an endorsement.

13.29(2) Removal of an endorsement; reinstatement of removed endorsement.

a. Removal of an endorsement. A practitioner may remove an endorsement from the practitioner's license as follows:

(1) To remove an endorsement, the practitioner shall meet the following conditions:

1. A practitioner who holds a standard or master educator license is eligible to request removal of an endorsement from the license if the practitioner has not taught in the subject or assignment area of the endorsement in the five years prior to the request for removal of the endorsement, and

2. The practitioner must submit a notarized written application form furnished by the board of educational examiners to remove an endorsement at the time of licensure renewal (licensure renewal is limited to one calendar year prior to the expiration date of the current license), and

3. The application must be signed by the superintendent or designee in the district in which the practitioner is under contract. The superintendent's signature shall serve as notification and acknowledgment of the practitioner's intent to remove an endorsement from the practitioner's license. The absence of the superintendent's or designee's signature does not impede the removal process.

(2) The endorsement shall be removed from the license at the time of application.

(3) If a practitioner is not employed and submits an application, the provisions of 13.29(2) "a"(1)"3" shall not be required.

(4) If a practitioner submits an application that does not meet the criteria listed in 13.29(2) "a"(1)"1" to "3," the application will be rendered void and the practitioner will forfeit the processing fee.

(5) The executive director has the authority to approve or deny the request for removal. Any denial is subject to the appeal process set forth in rule 282—11.35(272).

b. Reinstatement of a removed endorsement.

(1) If the practitioner wants to add the removed endorsement at a future date, all coursework for the endorsement must be completed within the five years preceding the application to add the endorsement.

(2) The practitioner must meet the current endorsement requirements when making application.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2584C, IAB 6/22/16, effective 7/27/16]

282—13.30(272) Licenses—issue and expiration dates, corrections, duplicates, and fraud.

13.30(1) Issue and expiration dates on original license. A license is valid only from and after the date of issuance. Licenses, authorizations, certificates, and statements of professional recognition will expire on the last day of the practitioner's birth month after the term of the license unless otherwise specified. If the expiration date is changed by rule, the change may be retroactive.

13.30(2) Correcting licenses. If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee

requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

13.30(3) Duplicate licenses. Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

13.30(4) Fraud in procurement or renewal of licenses. Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

[ARC 3979C, IAB 8/29/18, effective 10/3/18]

These rules are intended to implement Iowa Code chapter 272 and 2014 Iowa Acts, chapter 1116, division VI.

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² January 6, 2021, effective date of 13.6 [ARC 5303C, Item 1] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 14
SPECIAL EDUCATION ENDORSEMENTS
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 15]

282—14.1(272) Special education teaching endorsements.

14.1(1) Program requirements.

- a. The applicant must meet the requirement in rules 282—13.1(272) and 282—13.5(272).
- b. The applicant must complete pre-student teaching field-based experiences in special education.
- c. Student teaching. Each applicant for an Iowa license with a special education instructional endorsement must file evidence of completing an approved student teaching program in special education. This experience must be full-time in an approved special education classroom. An approved special education classroom is one which is recognized by the state in terms of the respective state rules for special education. This special education student teaching experience shall qualify for each special education instructional endorsement sought on an original application for Iowa licensure if at the same grade level.
- d. The applicant must meet the requirements to add an endorsement in rule 282—13.29(272).

14.1(2) Adding special education instructional endorsements to Iowa licenses.

- a. After the issuance of a practitioner license, an individual may add other special education instructional endorsements to that license upon proper application provided current requirements for the specific endorsement(s) have been met.
- b. If an applicant is seeking to add a special education instructional endorsement at the same level, elementary or secondary, as other endorsements held, the student teaching component set out in the rules for added endorsement areas is not required.
- c. If the applicant holds the K-8 special education endorsement for the 5-12 endorsement area being added, the applicant may satisfy the requirements for the secondary methods class and the student teaching experience by completing all the required coursework and presenting verification of competence of teaching a minimum of two years while properly licensed. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level.
- d. An updated license with expiration date unchanged from the original or renewed license will be prepared. Licensure procedures and requirements are set out in 282—Chapter 13.
[ARC 8248B, IAB 11/4/09, effective 10/12/09]

282—14.2(272) Specific requirements. For each of the following teaching endorsements in special education, the applicant must have completed 24 semester hours in special education.

14.2(1) Early childhood—special education.

- a. This endorsement authorizes instruction at the PK-K level only for instructional special education programs without regard to the instructional model.
- b. The applicant must present evidence of having completed the following program requirements.
 - (1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.
 - (2) Characteristics of learners. Preparation which includes an overview of current trends in educational programming and theories of child development, both typical and atypical; the identification of pre-, peri-, and postnatal development and factors that affect children's development and learning. Identification of specific disabilities, including the etiology, characteristics, and classification of common disabilities in young children. Application of the knowledge of cultural and linguistic diversity and the significant sociocultural context for the development of and learning in young children.
 - (3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology

used in the assessment of various disabling conditions. Assess children's cognitive, social-emotional, communication, motor, adaptive, and aesthetic development; and select, adapt, and administer assessment instruments and procedures for specific sensory and motor disabilities.

(4) **Methods and strategies.** Methods and strategies which include numerous models to plan and implement appropriate curricular and instructional practices based on knowledge of individual children, the family, the community, and curricular goals and content. Select intervention curricula and methods for children with specific disabilities including motor, sensory, health, communication, social-emotional and cognitive disabilities. Implement developmentally and functionally appropriate individual and group activities using a variety of formats; develop and implement an integrated curriculum that focuses on special education children from birth to age six, and incorporate information and strategies from multiple disciplines in the design of intervention strategies. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) **Managing student behavior and social interaction skills.** Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) **Communication and collaborative partnerships.** Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) **Student teaching.** Student teaching in a PK-K special education program.

14.2(2) Instructional strategist I: mild and moderate.

a. Option 1—K-8 mild and moderate. This endorsement authorizes instruction in all K-8 mild and moderate instructional special education programs without regard to the instructional model. An applicant for this option must complete the following requirement and must hold a regular education endorsement. See rule 282—13.26(272). The applicant must present evidence of having completed the following program requirements.

(1) **Foundations of special education.** The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

(2) **Characteristics of learners.** Preparation which includes various etiologies of mild and moderate disabilities, an overview of current trends in educational programming for mild and moderate disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming, and includes the general developmental, academic, social, career and functional characteristics of individuals with mild and moderate disabilities as the characteristics relate to levels of instructional support required, and the psychological and social-emotional characteristics of individuals with mild and moderate disabilities.

(3) **Assessment, diagnosis and evaluation.** Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) **Methods and strategies.** Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of the mildly and moderately disabled, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at the K-8 level. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) **Managing student behavior and social interaction skills.** Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) **Communication and collaborative partnerships.** Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) **Student teaching.** Student teaching in a K-8 mild and moderate special education program.

b. Option 2—K-8 mild and moderate. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-8 or 5-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out in paragraph 14.2(2) "a."

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) Methods and materials for teaching elementary language arts.

(3) Remedial reading.

(4) Elementary curriculum methods and material, unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).

(5) Methods and materials for teaching elementary mathematics.

c. Option 1—5-12 mild and moderate. This endorsement authorizes instruction in all 5-12 mild and moderate instructional special education programs without regard to the instructional model. An applicant for this option must complete the following requirements and must hold a regular education endorsement. See rule 282—13.28(272). The applicant must present evidence of having completed the following program requirements.

(1) **Foundations of special education.** The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

(2) **Characteristics of learners.** Preparation which includes various etiologies of mild and moderate disabilities, an overview of current trends in educational programming for mild and moderate disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming, and includes the general developmental, academic, social, career and functional characteristics of individuals with mild and moderate disabilities as the characteristics relate to levels of instructional support required, and the psychological and social-emotional characteristics of individuals with mild and moderate disabilities.

(3) **Assessment, diagnosis and evaluation.** Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any

specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of the mildly and moderately disabled, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at the 5-12 level. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals with mild and moderate disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in a 5-12 mild and moderate special education program.

d. Option 2—5-12 mild and moderate. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-8 or 5-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out in paragraph 14.2(2)“c.”

(1) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children, unless completed as part of the professional education core.

(2) Adolescent reading or secondary content area reading.

(3) Secondary or adolescent reading diagnosis and remediation.

(4) Methods and materials for teaching adolescents with mathematics difficulties or mathematics for the secondary level special education teacher.

(5) Secondary methods unless completed as part of the professional education core.

14.2(3) Instructional strategist II: behavior disorders/learning disabilities. This endorsement authorizes instruction in programs serving students with behavior disorders and learning disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies of behavior disorders and learning disabilities, an overview of current trends in educational programming for students with behavior disorders and learning disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from age 5 to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with behavior disorders and learning disabilities including the impact of such characteristics on classroom learning as well as associated domains such as social functioning and at-risk behaviors

which may lead to involvement with the juvenile justice or mental health system. Preparation in the psychological and social-emotional characteristics of individuals with behavior disorders and learning disabilities must include the major social characteristics of individuals with behavior disorders and the effects of dysfunctional behavior on learning, and the social and emotional aspects of individuals with learning disabilities including social imperceptiveness and juvenile delinquency. Physical development, physical disability and health impairments as they relate to the development and behavior of students with behavior disorders and the medical factors influencing individuals with learning disabilities, including intelligence, perception, memory and language development.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of behavior and learning disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with behavior and learning disabilities, including career, vocational and transitional support to postsecondary settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(4) Instructional strategist II: intellectual disabilities. This endorsement authorizes instruction in programs serving students with intellectual disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies of intellectual disabilities, an overview of current trends in educational programming for students with intellectual disabilities, educational alternatives and related services, and the importance of the multidisciplinary

team in providing more appropriate educational programming from age 5 to age 21. Preparation must also provide for an overview of the general developmental, academic, social, career and functional characteristics of individuals with intellectual disabilities as the characteristics relate to levels of instructional support required. This preparation must include the causes and theories of intellectual disabilities and implications and preventions; the psychological characteristics of students with intellectual and developmental disabilities, including cognition, perception, memory, and language development; medical complications and implications for student support needs, including seizure management, tube feeding, catheterization and CPR; and the medical aspects of intellectual disabilities and their implications for learning. The social-emotional aspects of intellectual disabilities, including adaptive behavior, social competence, social isolation and learned helplessness.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of intellectually disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Proficiency in adapting age-appropriate curriculum to facilitate instruction within the general education setting, to include partial participation of students in tasks, skills facilitation, collaboration, and support from peers with and without disabilities; the ability to select and use augmentative and alternative communications methods and systems. An understanding of the impact of speech-language development on behavior and social interactions. Approaches to create positive learning environments for individuals with special needs and approaches to utilize assistive devices for individuals with special needs. The design and implementation of age-appropriate instruction based on the adaptive skills of students with intellectual disabilities; integrate selected related services into the instructional day of students with intellectual disabilities. Knowledge of culturally responsive functional life skills relevant to independence in the community, personal living, and employment. Use of appropriate physical management techniques including positioning, handling, lifting, relaxation, and range of motion and the use and maintenance of orthotic, prosthetic, and adaptive equipment effectively.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with intellectual disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with intellectual disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(5) Instructional strategist II: physical disabilities. This endorsement authorizes instruction in programs serving students with physical disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies and characteristics of physical disabilities across the life span, secondary health care issues that accompany specific physical disabilities, an overview of current trends in educational programming for students with physical disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from age 5 to age 21. Preparation must also provide for an overview of the general developmental, academic, social, career and functional characteristics of individuals with physical disabilities as the characteristics relate to levels of instructional support required.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies.

(1) Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of physically disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(2) Research-supported instructional practices, strategies, and adaptations necessary to accommodate the physical and communication characteristics of students with physical disabilities, including appropriate assistive technology and alternative positioning to permit students with physical disabilities full participation and access to the general curriculum as well as social environments. Design and implement an instructional program that addresses instruction in independent living skills, vocational skills, and career education for students with physical disabilities and instructional strategies for medical self-management procedures by students.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with physical disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge

of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with physical disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(6) K-8 mildly disabled endorsement. This endorsement authorizes instruction to mildly disabled children who require special education program adaptations while assigned to a regular classroom for basic instructional purposes, or mildly disabled students placed in a special education class who receive part of their instruction in a regular classroom, or mildly disabled students requiring specially designed instruction while assigned to a regular classroom for basic instructional purposes. To fulfill the requirements for this endorsement, the applicant must:

a. Hold a regular education instruction endorsement at the elementary level. For the elementary level, this is the general elementary classroom endorsement.

b. Hold one of the following endorsements at the elementary level: learning disabilities, mild to moderate intellectual disabilities, behavioral disorders, multicategorical resource room or multicategorical-special class with integration.

14.2(7) 5-12 mildly disabled endorsement. This endorsement authorizes instruction to mildly disabled children who require special education program adaptations while assigned to a regular classroom for basic instructional purposes, or mildly disabled students placed in a special education class who receive part of their instruction in a regular classroom, or mildly disabled students requiring specially designed instruction while assigned to a regular classroom for basic instructional purposes. To fulfill the requirements for this endorsement, the applicant must:

a. Hold a regular education instruction endorsement at the secondary level (grades 5-12).

b. Hold one of the following endorsements at the secondary level: learning disabilities, mild to moderate intellectual disabilities, behavioral disorders, multicategorical resource room or multicategorical-special class with integration.

NOTE: These endorsements are designed for programs serving primarily mildly disabled students. Students who have sensory disorders are not included as “mildly disabled.”

14.2(8) Deaf or hard of hearing endorsement.

a. Option 1. This endorsement authorizes instruction in programs serving students with hearing loss from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). An applicant for this option must complete the following requirements and must have completed an approved program in teaching the deaf or hard of hearing from a recognized Iowa or non-Iowa institution and must hold a regular education endorsement. See 282—Chapter 13.

(1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, and including individuals from culturally and linguistically diverse backgrounds.

(2) Characteristics of learners. Preparation which includes various etiologies of hearing loss, an overview of current trends in educational programming for students with hearing loss and educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from birth to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with hearing loss, including the impact of such characteristics on classroom learning. Knowledge of the anatomy and physiology of the hearing mechanism and knowledge of the development of secondary senses when a hearing disorder is present, effect of hearing loss on learning experiences, psychological aspects of hearing loss, and effects of medications on the hearing system. Preparation in the psychological and social-emotional characteristics of individuals

with hearing loss to include the major social characteristics of individuals with hearing loss and the effects of this disability on learning, and the social and emotional aspects of individuals with hearing loss. Physical development and potential health implications as they relate to the development and behavior of students with hearing loss. Components of linguistic and nonlinguistic communication used by individuals who are deaf or hard of hearing and communication modes used by and with individuals who are deaf or hard of hearing, including current theories of language development in individuals who are deaf or hard of hearing.

(3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities, including necessary alternative assessment techniques arising out of the nature of the disability and medical reports and other related diagnostic information. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of students who are deaf or hard of hearing and sources of specialized materials for individuals who are deaf or hard of hearing. These strategies must include knowledge of teaching academic subjects and language and speech to students who are deaf or hard of hearing and have knowledge of American Sign Language. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals who are deaf or hard of hearing, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from birth to age 21. This preparation must include alternatives for teaching skills and strategies to individuals who are deaf or hard of hearing who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Strategies for teaching technology skills and other instructional aids for students who are deaf or hard of hearing.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities, including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals who are deaf or hard of hearing, including career, vocational and transitional support to postsecondary settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

b. Option 2. An applicant who holds an endorsement in deaf or hard of hearing issued in another state or who is eligible for such an endorsement but who does not also hold or is not eligible for a regular education endorsement in Iowa (see 282—Chapter 13) must meet the following basic requirements in addition to those set out in paragraph 14.2(8)“a.”

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children unless completed as part of the professional education core.

- (2) Methods and materials of teaching elementary language arts.
- (3) Methods and materials of teaching elementary reading.
- (4) Elementary curriculum methods and materials unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).
- (5) Methods and materials of teaching elementary mathematics.
- (6) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children unless completed as part of the professional education core.
- (7) Adolescent literacy or secondary content area reading.
- (8) Secondary methods unless completed as part of the professional education core.

14.2(9) Visually disabled endorsement.

a. Option 1. This endorsement authorizes instruction in programs serving students with visual disabilities from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). An applicant for this option must complete the following requirements and must have completed an approved program in visual disabilities from a recognized Iowa or non-Iowa institution and must hold a regular education endorsement. See 282—Chapter 13.

(1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, and including individuals from culturally and linguistically diverse backgrounds.

(2) Characteristics of learners. Preparation which includes various etiologies of visual impairment, an overview of current trends in educational programming for students with visual disabilities and educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from birth to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with visual disabilities, including the impact of such characteristics on classroom learning. Development of the human visual system, development of secondary senses when vision is impaired, effect of visual disability on development, impact of visual disability on learning and experiences, psychological aspects of visual disability, and effects of medications on the visual system. Preparation in the psychological and social-emotional characteristics of individuals with visual disabilities to include the major social characteristics of individuals with visual disabilities and the effects of this disability on learning, and the social and emotional aspects of individuals with visual disabilities. Physical development and potential health impairments as they relate to the development and behavior of students with visual disabilities.

(3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities, including necessary alternative assessment techniques arising out of the nature of the disability and medical reports and other related diagnostic information. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of visually disabled students and sources of curriculum materials for individuals with disabilities. These strategies must include knowledge of teaching Braille reading and writing, the skill in teaching handwriting and signature writing to individuals with low vision or who are blind, listening and compensatory auditory skills and typing and keyboarding skills. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with visual disabilities, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from birth to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with visual disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Strategies for teaching technology skills, other instructional aids for visually disabled students, strategies for teaching organization and study skills, tactual and perceptual skills, adapted physical and recreational skills and

strategies for promoting self-advocacy in individuals with visual disabilities and for structured pre-cane orientation and mobility assessment and instruction.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities, including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals with visual disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

b. Option 2. An applicant who holds an endorsement for visually disabled issued in another state or who is eligible for such an endorsement but who does not also hold or is not eligible for a regular education endorsement in Iowa (see 282—Chapter 13) must meet the following basic requirements in addition to those set out in paragraph 14.2(9)“a.”

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children unless completed as part of the professional education core.

(2) Methods and materials of teaching elementary language arts.

(3) Methods and materials of teaching elementary reading.

(4) Elementary curriculum methods and materials unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).

(5) Methods and materials of teaching elementary mathematics.

(6) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children unless completed as part of the professional education core.

(7) Adolescent literacy or secondary content area reading.

(8) Secondary methods unless completed as part of the professional education core.

[ARC 0450C, IAB 11/14/12, effective 12/19/12; ARC 1884C, IAB 2/18/15, effective 3/25/15; see Delay note at end of chapter and Nullification note at end of chapter; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 5802C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 1884C (Notice ARC 1602C, IAB 9/3/14), IAB 2/18/15, effective 3/25/15]^{1,2}

[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]

[Filed ARC 5802C (Notice ARC 5666C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

¹ March 25, 2015, effective date of ARC 1884C [14.2(10), 14.2(11)] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2015.

² See SJR 2006 of the 2016 Session of the Eighty-sixth General Assembly regarding nullification of 14.2(10) and 14.2(11) (ARC 1884C, IAB 2/18/15). Nullified language removed IAC Supplement 4/27/16.

CHAPTER 15
SPECIAL EDUCATION SUPPORT PERSONNEL AUTHORIZATIONS

282—15.1(272) Authorizations requiring a license.

15.1(1) The following licenses are based on teaching endorsements.

- a. Special education consultant.
- b. Supervisor of special education—instructional.
- c. Work experience coordinator.

15.1(2) Licensure procedures, requirements, and definitions are set out in 282—Chapter 13.
[ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—15.2(272) Special education consultant.

15.2(1) Authorization. The holder of this endorsement is authorized to serve as a special education consultant. The consultant provides ongoing assistance to instructional programs for pupils requiring special education. A consultant can serve programs with pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8) with the exception of consultants serving deaf or hard-of-hearing or visually disabled students. Applicants who desire to serve as consultants serving deaf or hard-of-hearing or visually disabled students must hold the respective special education instructional endorsement. The deaf or hard-of-hearing consultant endorsement or the visually disabled consultant endorsement allows the individual to serve students from birth to age 21.

15.2(2) Program requirements.

- a. An applicant must hold a master's degree.
 - (1) Option 1: Master's in special education.
 - (2) Option 2: Master's in another area of education plus an endorsement in at least one special education instructional area under rule 282—14.2(272).
 - b. Content. The coursework is to be at least 8 graduate semester hours to include the following:
 - (1) Curriculum development design.
 - (2) Consultation process in special or regular education:
 1. Examination, analysis, and application of a methodological model for consulting with teachers and other adults involved in the educational program.
 2. Interpersonal relations, interaction patterns, interpersonal influence, and communication skills.
 3. Skills required for conducting a needs assessment, delivering staff in-service needs, and evaluating in-service sessions.
- 15.2(3) Other.** An applicant must have four years of successful teaching experience, two of which must be in special education.

282—15.3(272) Itinerant hospital services or home services teacher. Rescinded ARC 3633C, IAB 2/14/18, effective 3/21/18.

282—15.4(272) Special education media specialist. Rescinded ARC 3633C, IAB 2/14/18, effective 3/21/18.

282—15.5(272) Supervisor of special education—instructional.

15.5(1) Authorization. The holder of this endorsement is authorized to serve as a supervisor of special education instructional programs. Two endorsements are available within this category:

- a. The early childhood—special education supervisor endorsement allows the individual to provide services to programs with pupils below the age of 7.
- b. The supervisor of special education—instructional endorsement (K-12) allows the individual to provide services to programs with pupils from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

15.5(2) Program requirements.

- a. An applicant must hold a master's degree.
 - (1) Option 1: Master's in special education.

(2) Option 2: Master's in another area of education plus 30 graduate semester hours in special education (instructional). These hours may have been part of, or in addition to, the degree requirements.

b. An applicant must meet the requirements for or hold the consultant endorsement.

c. Content. The program shall include a minimum of 16 graduate semester hours to specifically include the following:

(1) Coursework requirements specified for special education consultant. Refer to rule 282—15.2(272).

(2) Current issues in special education administration including school law/special education law.

(3) School personnel administration.

(4) Program evaluation.

(5) Educational leadership.

(6) Administration and supervision of special education.

(7) Practicum: special education administration. NOTE: This requirement may be waived based on two years of experience as a special education administrator.

(8) Evaluator approval component.

15.5(3) Other.

a. An applicant must have two years of consultant/supervisor/coordinator/head teacher or equivalent experience in special education.

b. The supervisor for early childhood—special education would need to meet the requirements for that endorsement. The K-12 supervisor would need to meet the requirements for one special education teaching endorsement to include instructional grade levels K-8 and 5-12.

[ARC 9073B, IAB 9/8/10, effective 10/13/10]

282—15.6(272) Work experience coordinator.

15.6(1) Authorization. The holder of this endorsement is authorized to provide support service as a work experience coordinator to secondary school programs, grades 5-12 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

15.6(2) Program requirements.

a. An applicant must hold a baccalaureate degree.

b. Content. The coursework must include:

(1) A course in career-vocational programming for special education students (if not included in the program for 5-12 endorsement).

(2) A course in coordination of cooperative occupational education programs.

(3) A course in career-vocational assessment and guidance for those with disabilities.

15.6(3) Other. An applicant must hold a special education endorsement—grades 5-12.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—15.7(272) Other special education practitioner endorsements. Rescinded ARC 5322C, IAB 12/16/20, effective 1/20/21.

282—15.8(272) Supervisor of special education—support. Rescinded IAB 7/29/09, effective 9/2/09. These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 0026C (Notice ARC 9924B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]

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[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 16
STATEMENTS OF PROFESSIONAL RECOGNITION (SPR)
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—16.1(272) Statement of professional recognition (SPR).

16.1(1) The following are authorizations that require or permit statements of professional recognition and licenses obtained from the professional licensure division, department of public health, or the board of nursing and that do not permit service as a teacher:

- a. School audiologist.
- b. School nurse.
- c. School occupational therapist.
- d. School physical therapist.
- e. School social worker.
- f. Special education nurse.
- g. Speech-language pathologist.
- h. School behavior analyst.
- i. Mental health professional.

16.1(2) Application. Statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the background check requirements set forth in rule 282—13.1(272).

16.1(3) Degrees. Degrees must be from a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

[ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5803C, IAB 7/28/21, effective 9/1/21; ARC 5807C, IAB 7/28/21, effective 7/8/21]

282—16.2(272) School audiologist. If an applicant has completed a master's degree in audiology but has not completed the education sequence or chooses not to be certified, the applicant must obtain a license from the Iowa board of speech pathology and audiology, department of public health. Additionally, the person is required to obtain an SPR from the board of educational examiners.

16.2(1) Authorization. The holder of this statement of professional recognition is authorized to serve as a school audiologist to pupils from birth to age 21 who are deaf or hard of hearing (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

16.2(2) Requirements. The special education director (or designee) of the area education agency must submit a letter requesting that the authorization be issued. The following documents must be included:

a. A copy of a temporary or regular license issued from the professional licensure division, department of public health.

b. An official transcript reflecting a master's degree in audiology.

16.2(3) Validity. The SPR shall be valid for five years.

16.2(4) Temporary authorization. A temporary SPR will be issued for one school year. An approved human relations course must be completed before the start of the next school year. The applicant must provide evidence that:

a. The applicant has completed the human relations component within the required time frame; and

b. The class of license from the professional licensure division is a regular license in the event a temporary license was issued initially.

[ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5802C, IAB 7/28/21, effective 9/1/21]

282—16.3(272) School nurse. A person who has passed the registered nurse examination and is licensed by the Iowa board of nursing may obtain a statement of professional recognition (SPR) from the board of educational examiners.

16.3(1) Authorization. The holder of an SPR is authorized to promote the health and safety of the students in an accredited school district, including providing medical treatment as allowed under the authority granted by virtue of holding a license from the Iowa board of nursing.

16.3(2) Requirements.

a. Applicant has passed the registered nurse examination, is licensed by the Iowa board of nursing and has a baccalaureate degree.

b. While employed by an accredited K-12 school district, applicant maintains licensure with the Iowa board of nursing.

16.3(3) Validity. The school nurse SPR shall be valid for five years.

16.3(4) Local requirements. A school district may require an SPR, but the board of educational examiners does not require an SPR for nurses working in a school district.

16.3(5) Renewal. Renewal requirements for the SPR:

a. Applicant must apply for renewal every five years.

b. Applicant must maintain continual licensure with the Iowa board of nursing.

c. Applicant must complete continuing education as required by the Iowa board of nursing.

282—16.4(272) School occupational therapist. A person who holds a degree or equivalent baccalaureate in occupational therapy and a valid license to practice occupational therapy in Iowa as granted by the professional licensure division, department of public health, may obtain a statement of professional recognition (SPR) by the board of educational examiners.

16.4(1) Authorization. The holder of this authorization may serve as a school occupational therapist to pupils from birth to age 21 who have physical impairments (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The legalization for this support personnel is through a statement of professional recognition (SPR) and not through teacher licensure.

16.4(2) Requirements.

a. The special education director (or designee) of the area education agency must submit a letter to the board of educational examiners to request that the authorization be issued.

b. An applicant must also submit the following documents:

(1) A copy of a temporary or regular license from the professional licensure division, department of public health.

(2) An official transcript.

16.4(3) Validity. The SPR shall be valid for five years.

16.4(4) Temporary authorization. A temporary SPR will be issued for one school year if the class of license from the professional licensure division is temporary. A regular SPR will be issued with verification of a regular license and of at least a bachelor's degree in occupational therapy.

282—16.5(272) School physical therapist. A person who holds a degree or equivalent baccalaureate in physical therapy and a valid license to practice physical therapy in Iowa as granted by the professional licensure division, department of public health, may be issued a statement of professional recognition (SPR) by the board of educational examiners.

16.5(1) Authorization. The holder of this authorization can serve as a school physical therapist to pupils from birth to age 21 who have physical impairments (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The legalization for this support service personnel is through a statement of professional recognition (SPR) and not through teacher licensure.

16.5(2) Requirements.

a. The special education director (or designee) of the area education agency must submit a letter to the board of educational examiners to request that the authorization be issued.

b. An applicant must also submit the following documents:

(1) A copy of a temporary or regular license from the professional licensure division, department of public health.

(2) An official transcript.

16.5(3) Validity. The SPR shall be valid for five years.

16.5(4) Temporary authorization. A temporary SPR will be issued for one school year if the class of license from the professional licensure division is temporary. A regular SPR will be issued with verification of a regular license and of at least a bachelor's degree in physical therapy.

282—16.6(272) School social worker. A person who meets the requirements set forth below may be issued a statement of professional recognition (SPR) by the board of educational examiners.

16.6(1) Authorization. The holder of this statement of professional recognition is authorized to serve as a school social worker to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

16.6(2) Requirements. The special education director (or designee) of the area education agency or local education agency must submit an application to request that the authorization be issued. The application must include:

- a. An official transcript that reflects the master's degree in social work; and
- b. The licensed independent social worker (LISW) or licensed master social worker (LMSW) license issued by the Iowa board of social work.

16.6(3) Validity. The SPR shall be valid for five years.

16.6(4) Temporary authorization. A temporary SPR will be issued for one school year if the class of license from the professional licensure division is temporary. A regular SPR will be issued with verification of a regular license and a master's degree in social work.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—16.7(272) Special education nurse. A person who holds a baccalaureate degree in nursing or a master's degree in nursing, holds current licensure in the state of Iowa by the board of nursing and has two years' experience in public health nursing including service to schools or as a school nurse may be issued a statement of professional recognition (SPR) by the board of educational examiners.

16.7(1) Authorization. The holder of this authorization is authorized to serve as a special education nurse to pupils from birth to age 21 requiring special education (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The legalization for this support service personnel is through a statement of professional recognition (SPR) and not through teacher licensure.

16.7(2) Requirements.

a. The special education director (or designee) of the area education agency must submit a letter to the board of educational examiners to request that the SPR be issued.

b. An applicant must submit the following documents:

- (1) A copy of the license issued by the Iowa board of nursing.
- (2) An official transcript.
- (3) Verification of two years' experience in public health nursing.
- (4) Completion of an approved human relations course.

16.7(3) Validity. The SPR shall be valid for five years.

16.7(4) Temporary authorization. A temporary SPR will be issued for one school year. The applicant must provide evidence that:

a. A professional registered nurse who does not meet the criteria set forth in rule 282—16.7(272) must complete six semester credits of graduate or undergraduate coursework in special education within one school year after receiving temporary authorization; and

b. An approved human relations course must be completed before the start of the next school year.

282—16.8(272) Speech-language pathologist. If an applicant has completed a master's degree in speech pathology but has not completed the education sequence or chooses not to be certified, the applicant must obtain a license from the Iowa board of speech pathology and audiology, department of public health. Additionally, the person is required to obtain an SPR from the board of educational examiners.

16.8(1) Authorization. The holder of this statement of professional recognition is authorized to serve as a speech-language pathologist to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

16.8(2) Requirements. The special education director (or designee) of the area education agency must submit a letter requesting that the authorization be issued. The following documents must be included:

- a. A copy of a temporary or regular license issued from the professional licensure division, department of public health.
- b. An official transcript reflecting a master's degree in speech pathology.

16.8(3) Validity. The SPR shall be valid for five years.

16.8(4) Temporary authorization. A temporary SPR will be issued for one school year. An approved human relations course must be completed before the start of the next school year. The applicant must provide evidence that:

- a. The applicant has completed the human relations component within the required time frame; and
- b. The class of license from the professional licensure division is a regular license in the event a temporary license was issued initially.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—16.9(272) School behavior analyst. A person who has obtained a master's degree and board-certified behavior analyst certification and who is licensed by the Iowa board of behavioral science may obtain a statement of professional recognition (SPR) from the board of educational examiners.

16.9(1) Authorization. The holder of this authorization can serve as a school behavior analyst to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The legalization for this support service personnel is through an SPR and not through teacher licensure.

16.9(2) Requirements.

a. The special education director (or designee) of the school district or area education agency must submit a letter to the board of educational examiners to request that the authorization be issued.

b. An applicant must also submit the following documents:

- (1) A copy of a temporary or regular license from the board of behavioral science.
- (2) An official transcript.

c. While employed by an accredited K-12 school district or area education agency, the applicant must also maintain licensure with the Iowa board of behavioral science.

16.9(3) Validity. The SPR shall be valid for five years.

16.9(4) Temporary authorization. A temporary SPR will be issued for one school year if the class of license from the professional licensure division is temporary. A regular SPR will be issued with verification of a regular license.

[ARC 5807C, IAB 7/28/21, effective 7/8/21]

282—16.10(272) Mental health professional. A mental health professional pursuant to Iowa Code section 228.1 who has obtained a license from a bureau under the Iowa department of public health shall obtain a statement of professional recognition (SPR) from the board of educational examiners to be employed by or provide services to an accredited public or private school.

16.10(1) Authorization. The holder of this authorization can serve as a mental health professional to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The legalization for this support service personnel is through an SPR and not through teacher licensure.

16.10(2) Requirements.

a. An administrator for the school or area education agency must submit a form to the board of educational examiners to request that the authorization be issued.

b. An applicant must also submit the following documents:

(1) A copy of a temporary or regular license from the relevant bureau of the Iowa department of public health.

(2) An official transcript.

c. While employed by or providing services to an accredited public or private school or area education agency, the applicant must also maintain licensure with the relevant bureau of the Iowa department of public health.

d. Social workers shall instead obtain the professional service license or SPR specific to school social work which includes the authorization to provide mental health services to an accredited public or private school or area education agency.

16.10(3) *Validity.* The SPR shall be valid for five years.

16.10(4) *Temporary authorization.* A temporary SPR will be issued for one school year if the class of license from the professional licensure division is temporary. A regular SPR will be issued with verification of a regular license.

[ARC 5807C, IAB 7/28/21, effective 7/8/21]

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 18
ISSUANCE OF ADMINISTRATOR LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—18.1(272) All applicants desiring an Iowa administrator license.

18.1(1) Definitions.

“*Coursework*” means requirements completed for semester hour credit through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*Degree*” means a specific qualification earned through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*Recognized non-Iowa institution*” means an institution that is state-approved and is accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

“*State-approved*” means a program for administrator preparation approved for state licensure.

18.1(2) Administrator licenses. Administrator licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the background check requirements set forth in rule 282—13.1(272).

18.1(3) Temporary permits. The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check and registries and records check set forth in 282—paragraphs 13.1(2) “*b*” and “*c*.” The temporary permit shall serve as evidence of the applicant’s authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

[ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 2631C, IAB 7/20/16, effective 8/24/16; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—18.2(272) Applicants from recognized Iowa institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—18.3(272) Applicants from recognized non-Iowa institutions. Rescinded IAB 9/9/09, effective 10/14/09.

282—18.4(272) General requirements for an administrator license.

18.4(1) Eligibility for applicants who have completed a teacher preparation program. Applicants for the administrator license must first comply with the requirements for all Iowa practitioners set out in 282—Chapter 13.

18.4(2) Specific requirements for an initial administrator license for applicants who have completed a teacher preparation program. An initial administrator license valid for a minimum of one year with an expiration date of June 30 may be issued to an applicant who:

- a. Has completed a state-approved PK-12 principal and PK-12 supervisor of special education program (see subrule 18.9(1)); and
- b. Has completed an evaluator approval program; and
- c. Provides a recommendation for the specific license and administrator endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed; and
- d. Has met the experience requirement set forth for the desired administrator endorsement; and
- e. Is not subject to any pending disciplinary proceedings in any state; and
- f. Complies with all requirements with regard to application processes and payment of licensure fees.

18.4(3) *Eligibility for applicants who have completed a professional service endorsement program.* Applicants for the administrator license must first comply with the requirements set out in 282—Chapter 27.

18.4(4) *Specific requirements for an initial administrator license for applicants who have completed a professional service endorsement.* An initial administrator license valid for one year may be issued to an applicant who:

- a. Is the holder of an Iowa professional service license; and
- b. Has three years of experience in an educational setting in the professional service endorsement area or has six years of professional service and administrative experience provided that at least two years are professional service experience; and
- c. Has completed a state-approved PK-12 principal and PK-12 supervisor of special education program (see subrule 18.9(1)); and
- d. Is assuming a position as a PK-12 principal and PK-12 supervisor of special education (see subrule 18.9(1)) for the first time or has one year of out-of-state or nonpublic administrative experience; and
- e. Has completed the required coursework in human relations, cultural competency, diverse learners and reading instruction set forth in 281—subrules 79.15(2) and 79.15(3); and
- f. Has completed the professional education core in 281—paragraphs 79.15(5) “a” to “k”; and
- g. Has completed an evaluator approval program.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 8958B, IAB 7/28/10, effective 9/1/10; ARC 1326C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2631C, IAB 7/20/16, effective 8/24/16; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 3979C, IAB 8/29/18, effective 10/3/18]

282—18.5(272) Specific requirements for a professional administrator license. A professional administrator license valid for five years may be issued to an applicant who does all of the following:

18.5(1) Completes the requirements in rule 282—18.4(272).

18.5(2) Successfully meets each standard pursuant to rule 281—83.10(284A).

18.5(3) Completes one year of administrative experience in an Iowa public school and completes the administrator mentoring program while holding an administrator license, or successfully completes two years of administrative experience in a nonpublic or out-of-state school setting.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 0607C, IAB 2/20/13, effective 3/27/13; ARC 5322C, IAB 12/16/20, effective 1/20/21]

282—18.6(272) Specific requirements for an administrator prepared out of state. An applicant seeking Iowa licensure who completes an administrator preparation program from a recognized non-Iowa institution shall verify the requirements of rules 282—18.1(272) and 282—18.4(272) through a transcript review. Applicants must hold and submit a copy of a valid or expired regular administrator certificate or license in another state, exclusive of a temporary, emergency or substitute license or certificate.

18.6(1) *Administrator exchange license.* A one-year nonrenewable administrator exchange license may be issued to an individual who:

- a. Has met a minimum of 75 percent of the coursework requirements for administrative licensure but has some coursework deficiencies.
- b. Is eligible for and has applied for a regular valid and current out-of-state administrator license and is waiting for the processing of the license.
- c. Has not completed the approved evaluator training requirement.

18.6(2) *Conversion.* Each applicant who receives the one-year administrator exchange license must complete any identified coursework deficiencies in order to be eligible for an initial administrator license or a professional administrator license in Iowa. Any coursework deficiencies must be completed for college credit, with the exception of the human relations component which may be taken for licensure renewal credit through an approved provider.

18.6(3) License without deficiencies. An applicant under this rule shall be granted an Iowa administrator license and will not be subject to coursework deficiencies if the following additional requirements have been met:

a. Verification of Iowa residency, or, for military spouses, verification of a permanent change of military installation.

b. Valid or expired administrator certificate or license in good standing without pending disciplinary action from another state, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate. Endorsements shall be granted based on comparable Iowa endorsements, and endorsement requirements may be waived in order to grant the most comparable endorsement.

18.6(4) Holders of an Iowa administrator exchange license issued prior to January 1, 2021, may submit a new application if the requirements in this rule would have been met at the time of their initial application.

[ARC 8141B, IAB 9/9/09, effective 10/14/09; ARC 9383B, IAB 2/23/11, effective 3/30/11; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5321C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—18.7(272) Specific requirements for a Class A extension license.

18.7(1) A nonrenewable Class A extension license valid for one year may be issued to an applicant based on an expired Iowa professional administrator license. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

18.7(2) The holder of an expired professional administrator license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the administrator license held shall be required to secure the signature of the superintendent or designee before the Class A extension license will be issued. If the superintendent does not meet the renewal requirements, the superintendent shall be required to secure the signature of the school board president before the license will be issued.

[ARC 9384B, IAB 2/23/11, effective 3/30/11; ARC 9453B, IAB 4/6/11, effective 5/11/11; ARC 0564C, IAB 1/23/13, effective 2/27/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.8(272) Specific requirements for a Class B license. A nonrenewable Class B license valid for two years may be issued to an individual under the following conditions:

18.8(1) Endorsement in progress. The individual has a valid Iowa teaching license but is seeking to obtain an administrator endorsement. A Class B license may be issued if requested by an employer and the individual seeking this endorsement has completed at least 75 percent of the requirements leading to completion of all requirements for this endorsement.

18.8(2) Experience requirement.

a. Principal endorsement. For the principal endorsement, the applicant must meet the experience requirement set forth in subparagraph 18.9(1)“c”(1).

b. Superintendent endorsement. For the superintendent endorsement, the applicant must meet the experience requirement set forth in subrule 18.10(3).

18.8(3) Request for exception. Rescinded IAB 2/23/11, effective 3/30/11.
[ARC 9385B, IAB 2/23/11, effective 3/30/11; ARC 2631C, IAB 7/20/16, effective 8/24/16]

282—18.9(272) Area and grade levels of administrator endorsements.

18.9(1) PK-12 principal and PK-12 supervisor of special education.

a. Authorization. The holder of this endorsement is authorized to serve as a principal of programs serving children from birth through grade twelve, a supervisor of instructional special education programs for children from birth to the age of 21, and a supervisor of support for special education programs for children from birth to the age of 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) Degree—master’s.

(2) Content: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. Candidates who successfully complete a building-level educational leadership preparation program understand and demonstrate the capacity to promote the current and future success and well-being of each student and adult by applying the knowledge, skills, and commitments necessary to:

1. Collaboratively lead, design, and implement a school mission, vision, and process for continuous improvement that reflects a core set of values and priorities that include data use, technology, equity, diversity, digital citizenship, and community (Mission, Vision, and Improvement).

2. Advocate for ethical decisions and cultivate and enact professional norms (Ethics and Professional Norms).

3. Develop and maintain a supportive, equitable, culturally responsive, and inclusive school culture (Equity, Inclusiveness, and Cultural Responsiveness) to include meeting the needs of all learners, as well as ensuring teachers meet the needs of diverse learners, including:

- Students from diverse ethnic, racial and socioeconomic backgrounds.
- Students with disabilities, including preparation in developing and implementing individualized education programs and behavioral intervention plans, preparation for educating individuals in the least restrictive environment and identifying that environment, and strategies that address difficult and violent student behavior and improve academic engagement and achievement.

- Students who are struggling with literacy, including those with dyslexia.

- Students who are gifted and talented.

- English language learners.

- Students who may be at risk of not succeeding in school. This preparation will include classroom management addressing high-risk behaviors including, but not limited to, behaviors related to substance abuse.

4. Evaluate, develop, and implement coherent systems of curriculum, instruction, data systems, supports, and assessment (Learning and Instruction).

5. Strengthen student learning, support school improvement, and advocate for the needs of their school and community (Community and External Leadership).

6. Improve management, communication, technology, school-level governance, and operation systems to develop and improve data-informed and equitable school resource plans and to apply laws, policies, and regulations, including a dedicated course in current issues of special education administration (Operations and Management).

7. Build the school's professional capacity, engage staff in the development of a collaborative professional culture, and improve systems of staff supervision, evaluation, support, and professional learning, including the completion of Iowa evaluator training (Building Professional Capacity).

8. Successfully complete an internship under the supervision of knowledgeable, expert practitioners that engages candidates in multiple and diverse school settings and provides candidates with coherent, authentic, and sustained opportunities to synthesize and apply the knowledge and skills pursuant to this section in ways that approximate the full range of responsibilities required of building-level leaders and enable them to promote the current and future success and well-being of each student and adult in their school, including planned experiences in elementary and secondary administration with special education administration.

c. Other.

(1) The applicant must have had three years of teaching experience at the early childhood through grade twelve level while holding a valid license or have had six years of teaching and administrative experience while holding a valid license, provided that at least two years are teaching experience.

(2) Graduates from out-of-state institutions who are seeking initial Iowa licensure and the PK-12 principal and PK-12 supervisor of special education endorsement must meet the coursework requirements for an Iowa teaching license in addition to the experience requirements.

18.9(2) *PK-8 principal—out-of-state applicants.* Rescinded IAB 7/20/16, effective 8/24/16.

18.9(3) 5-12 principal—out-of-state applicants. Rescinded IAB 7/20/16, effective 8/24/16.
 [ARC 0872C, IAB 7/24/13, effective 8/28/13; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2631C, IAB 7/20/16, effective 8/24/16; ARC 5322C, IAB 12/16/20, effective 1/20/21]

282—18.10(272) Superintendent/AEA administrator.

18.10(1) Authorization. The holder of this endorsement is authorized to serve as a superintendent from the prekindergarten level through grade twelve or as an AEA administrator. NOTE: This authorization does not permit general teaching, school service, or administration at any level except that level or area for which the practitioner holds the specific endorsement(s).

18.10(2) Program requirements.

a. Degree—specialist (or its equivalent: A master’s degree plus at least 30 semester hours of planned graduate study in administration beyond the master’s degree).

b. Content. Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, candidates who successfully complete a district-level educational leadership preparation program understand and demonstrate the capacity to promote the current and future success and well-being of each student and adult by applying the knowledge, skills, and commitments necessary to:

(1) Collaboratively lead, design, and implement a district mission, vision, and process for continuous improvement that reflects a core set of values and priorities that include data use, technology, values, equity, diversity, digital citizenship, and community (District Mission, Vision, and Improvement).

(2) Advocate for ethical decisions and cultivate professional norms and culture (Ethics and Professional Norms).

(3) Develop and maintain a supportive, equitable, culturally responsive, and inclusive district culture (Equity, Inclusiveness, and Cultural Responsiveness) to include meeting the needs of all learners, as well as ensuring teachers meet the needs of diverse learners, including:

1. Students from diverse ethnic, racial and socioeconomic backgrounds.

2. Students with disabilities, including preparation in developing and implementing individualized education programs and behavioral intervention plans, preparation for educating individuals in the least restrictive environment and identifying that environment, and strategies that address difficult and violent student behavior and improve academic engagement and achievement.

3. Students who are struggling with literacy, including those with dyslexia.

4. Students who are gifted and talented.

5. English language learners.

6. Students who may be at risk of not succeeding in school. This preparation will include classroom management addressing high-risk behaviors including, but not limited to, behaviors related to substance abuse.

(4) Evaluate, design, cultivate, and implement coherent systems of curriculum, instruction, data systems, supports, assessment, and instructional leadership (Learning and Instruction).

(5) Understand and engage families, communities, and other constituents in the work of schools and the district and to advocate for district, student, and community needs (Community and External Leadership).

(6) Develop, monitor, evaluate, and manage data-informed and equitable district systems for operations, resources, technology, and human capital management, including instructional and noninstructional district support services (Operations and Management).

(7) Cultivate relationships, lead collaborative decision making and governance, and represent and advocate for district needs in broader policy conversations (Policy, Governance, and Advocacy).

(8) Successfully complete an internship under the supervision of knowledgeable, expert practitioners that engages candidates in multiple and diverse district settings and provides candidates with coherent, authentic, and sustained opportunities to synthesize and apply the knowledge and skills identified in this section in ways that approximate the full range of responsibilities required of

district-level leaders and enable them to promote the current and future success and well-being of each student and adult in their district.

18.10(3) Administrative experience. The applicant must meet one of the following:

a. The applicant must have had three years of experience as a building principal while holding a valid license.

b. The applicant must have three years of administrative experience in any of the following areas: PK-12 regional education agency administrative experience, PK-12 state department of education administrative experience, PK-12 educational licensing board administrative experience or PK-12 building/district administrative experience while holding a valid Iowa administrator license.

c. The applicant must have six years of teaching and administrative experience, provided that at least two years are teaching experience and one year is administrative experience, all while holding a valid license.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 0872C, IAB 7/24/13, effective 8/28/13; ARC 1167C, IAB 11/13/13, effective 12/18/13; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 5322C, IAB 12/16/20, effective 1/20/21]

282—18.11(272) Director of special education of an area education agency.

18.11(1) Authorization. The holder of this endorsement is authorized to serve as a director of special education of an area education agency. Assistant directors are also required to hold this endorsement.

18.11(2) Program requirements.

a. Degree—master's.

b. Endorsement. An applicant must hold or meet the requirements for one of the following:

- (1) PK-12 principal and PK-12 supervisor of special education (see rule 282—18.9(272));
- (2) Supervisor of special education—instructional (see rule 282—15.5(272));
- (3) Professional service administrator (see 282—subrule 27.3(5)); or
- (4) A letter of authorization for special education supervisor issued prior to October 1, 1988.

c. Content. An applicant must have completed a sequence of courses and experiences of at least 24 additional semester hours to include the following:

(1) Understand and demonstrate the capacity to advocate for ethical decisions and cultivate professional norms and culture.

(2) Develop and maintain a safe, supportive, equitable, culturally responsive, and inclusive district culture.

(3) Collaboratively lead, design, and implement a district mission, vision, and process for continuous improvement that reflects a core set of values and priorities that include data use, technology, values, equity, diversity, digital citizenship, and community.

(4) Knowledge of current issues in special education and special education administration.

(5) Knowledge of special education school law and legislative and public policy issues affecting children and families.

(6) Knowledge of the powers and duties of the director of special education of an area education agency as delineated in Iowa Code section 273.5.

(7) Practicum in administration and supervision of special education programs.

d. Experience. An applicant must meet the experience requirement set forth in 18.10(3).

18.11(3) Other.

a. Option 1: Instructional. An applicant must meet the requirements for one special education teaching endorsement and have three years of teaching experience in special education.

b. Option 2: Support. An applicant must meet the practitioner licensure requirements for one of the following endorsements and have three years of experience as a:

- (1) School audiologist;
- (2) School psychologist;
- (3) School social worker; or

(4) Speech-language pathologist.

NOTE: An individual holding a statement of professional recognition is not eligible for the director of special education of an area education agency endorsement.

[ARC 9075B, IAB 9/8/10, effective 10/13/10; ARC 2631C, IAB 7/20/16, effective 8/24/16; ARC 5322C, IAB 12/16/20, effective 1/20/21]

282—18.12(272) Specific requirements for a Class E emergency license. A nonrenewable Class E emergency license valid for one year may be issued to an individual as follows.

18.12(1) Expired license. Based on an expired Class A, Class B, or administrator exchange license, the holder of the expired license shall be eligible to receive a Class E license upon application and submission of all required materials.

18.12(2) Application. The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to obtain full licensure, and registration for coursework to be completed during the term of the Class E license. The Class E license will be denied if the applicant has not completed any coursework during the term of the Class A, Class B, or administrator exchange license unless extenuating circumstances are verified.
[ARC 0874C, IAB 7/24/13, effective 8/28/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.13 Reserved.

282—18.14(272) Endorsements.

18.14(1) After the issuance of an administrator license, an individual may add other administrator endorsements to that license upon proper application, provided current requirements for that endorsement, as listed in rules 282—18.9(272) through 282—18.11(272), have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

18.14(2) The applicant must follow one of these options:

- a. Identify with a recognized Iowa administrator preparing institution, meet that institution's current requirements for the endorsement desired, and receive that institution's recommendation; or
- b. Identify with a recognized non-Iowa administrator preparation institution and receive a statement that the applicant has completed the equivalent of the institution's approved program for the endorsement sought. A transcript evaluation will also be required.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

282—18.15(272) Licenses—issue dates, corrections, duplicates, and fraud.

18.15(1) Issue date on original license. A license is valid only from and after the date of issuance.

18.15(2) Correcting licenses. If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

18.15(3) Duplicate licenses. Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

18.15(4) Fraud in procurement or renewal of licenses. Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 3979C (Notice ARC 3827C, IAB 6/6/18), IAB 8/29/18, effective 10/3/18]
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[Filed ARC 5321C (Notice ARC 5216C, IAB 10/7/20), IAB 12/16/20, effective 1/20/21]
[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 20 RENEWALS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 17]

282—20.1(272) General renewal information. This chapter contains renewal requirements for those individuals desiring to renew the initial, standard, master educator, professional administrator, or substitute license or a statement of professional recognition (SPR). Individuals desiring to renew a license issued under some other title are referred to 282—Chapters 22, 23, and 24.
[ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.2(272) Renewal application forms. Application forms for renewal may be obtained from the board of educational examiners' website at www.boee.iowa.gov or by contacting the office at (515)281-3245.

282—20.3(272) Renewal of licenses.

20.3(1) Issue date. A renewed license is valid only from and after the date of issuance.

20.3(2) General renewal requirements. A license may be renewed for applicants who fulfill the general requirements set out in subrules 20.3(3) through 20.3(5) and the license-specific requirements set out in this chapter under each license.

20.3(3) Background check. Every applicant for renewal or conversion is required to submit a completed application form with the applicant's signature to facilitate a check of the sex offender registry information under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the Iowa court information system. The board may assess the applicant a fee no greater than the costs associated with obtaining and evaluating the background check.

20.3(4) Child and dependent adult abuse trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse trainings approved by the department of human services. The completion documentation must be no more than three years old at the time of application. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

- a. A person is engaged in active duty in the military service of this state or of the United States.
- b. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.
- c. A person is practicing a licensed profession outside this state.
- d. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

20.3(5) Recency of units for renewal. If a license is renewed on or before the date of expiration, the units for renewal are acceptable if earned during the term of the license. If a license is not renewed on the date of expiration, the units for renewal must have been completed within the five-year period immediately preceding the date of application for the renewal.

20.3(6) Timely renewal. A license may only be renewed less than one year before it expires.

20.3(7) College or university degrees and credit. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

[ARC 9451B, IAB 4/6/11, effective 5/11/11; ARC 0026C, IAB 3/7/12, effective 4/11/12; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.4(272) Specific renewal requirements for the initial license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). If a person meets all requirements for the standard license except for the options required in rule 282—13.7(272), paragraph “2,” the initial license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the options required in rule

282—13.7(272), paragraph “2,” and if the license holder can provide evidence of teaching employment which will be acceptable for the experience requirement. A Class A license may be issued instead of the renewal of the initial license for another initial license if the applicant verifies one of the following:

1. The applicant is involved in the second year of the mentoring and induction program, but the license will expire before the second year of teaching is completed.
2. The applicant has taught for two years in a nonpublic school setting and needs one additional year of teaching to convert the initial license to the standard license.

[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—20.5(272) Specific renewal requirements for the standard license.

20.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.5(2) Six units are needed for renewal. These units may be earned in any combination listed as follows:

- a. One unit may be earned for each semester hour of graduate credit which leads toward the completion of a planned master’s, specialist’s, or doctor’s degree program.
- b. One unit may be earned for each semester hour of graduate or undergraduate credit which may not lead to a degree but which adds greater depth/breadth to present endorsements held.
- c. One unit may be earned for each semester hour of credit which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.
- d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.
- e. Four units may be earned for successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or master educator license. Four units may also be earned for each National Board for Professional Teaching Standards certification renewal and may be used toward the subsequent renewal of either the standard or master educator license.
- f. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator.

[ARC 2120C, IAB 9/2/15, effective 10/7/15; ARC 2587C, IAB 6/22/16, effective 7/27/16; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.6(272) Specific renewal requirements for a master educator license.

20.6(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.6(2) Four units are needed for renewal. For an applicant who also holds a specialist’s or doctor’s degree, two units are needed for renewal. These units may be earned in any combination listed below:

- a. One unit may be earned for each semester hour of graduate credit which leads toward the completion of a planned master’s, specialist’s, or doctor’s degree program.
- b. One unit may be earned for each semester hour of graduate or undergraduate credit which may not lead to a degree but which adds greater depth/breadth to present endorsements held.
- c. One unit may be earned for each semester hour of credit which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.
- d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.
- e. Four units may be earned upon successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or master educator license. Four units may also be earned for each National Board for Professional Teaching Standards certification renewal and may be used toward the subsequent renewal of either the standard or master educator license.
- f. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator.

[ARC 2120C, IAB 9/2/15, effective 10/7/15; ARC 2587C, IAB 6/22/16, effective 7/27/16; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.7(272) Specific renewal requirements for a substitute license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). An applicant for renewal of a substitute license shall meet one of the requirements listed below:

1. Verification of at least 30 days of substitute teaching during the term of the license or one year of teaching experience within the last five years completed during the term of a valid Iowa teaching license.

2. Completion of one licensure renewal credit approved through licensure renewal guidelines established by the board of educational examiners.

3. Completion of one semester hour of credit taken from a community college, college, or university.

[ARC 7988B, IAB 7/29/09, effective 9/2/09; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.8(272) Specific renewal requirements for the initial administrator license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.8(1) Requirements. If an applicant meets all requirements for the professional administrator license except for the requirements in 282—subrule 18.5(3), the initial administrator license may be renewed upon written request. A second renewal may be granted if the holder of the initial administrator license has not met the requirements in 282—subrule 18.5(3) and if the license holder can provide evidence of employment as a PK-12 administrator, which meets the experience requirement.

20.8(2) Extension. An extension of the initial administrator license may be issued instead of the renewal of the initial administrator license if the applicant verifies one of the following:

a. The applicant is involved in a mentoring and induction program, but the license will expire before the first year of administrative experience is completed.

b. The applicant has one year of administrative experience in a nonpublic school setting or in an out-of-state setting and needs one additional year of administrative experience to convert the initial license to the professional license.

[ARC 2017C, IAB 6/10/15, effective 7/15/15; ARC 3196C, IAB 7/5/17, effective 8/9/17]

282—20.9(272) Specific renewal requirements for an administrator license.

20.9(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.9(2) Four units are needed for renewal. For an applicant who also holds a specialist's or doctor's degree, two units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit which leads toward the completion of a planned specialist's or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit which may not lead to a degree but which leads to completion of requirements for an administrator endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

e. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator, or in the case of a superintendent, as verified by the school board president.

20.9(3) Evaluator training. An applicant renewing an administrator license must submit documentation of completion of the evaluator training required in Iowa Code section 284.10. A waiver of the evaluator training may apply under the following conditions with appropriate documentation of any of the following:

a. The person is engaged in active duty in the military service of this state or of the United States.

b. The application of the evaluator training would impose an undue hardship on the person for whom the waiver is requested.

c. The person is practicing in a licensed profession outside this state.
[ARC 2587C, IAB 6/22/16, effective 7/27/16; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—20.10(272) Renewal requirements for a statement of professional recognition (SPR).

20.10(1) Renewal of the SPR.

a. The applicant must:

- (1) Apply for renewal every five years.
- (2) Maintain continual licensure with the board with which the applicant holds other licensure.
- (3) Complete continuing education as required by the board with which the applicant holds other licensure.

b. The SPR shall be valid for five years.

c. The fee for issuance of the SPR certificate shall be the same as for a standard license as set forth in 282—Chapter 12. All fees are nonrefundable.

20.10(2) Each applicant renewing an SPR must provide documentation that all renewal requirements in subrules 20.3(1) through 20.3(4) have been met.

282—20.11(272) Audit of applications for license renewal. The board will randomly audit a minimum of 10 percent of the applications for renewal of the standard, master educator, and administrator licenses.

20.11(1) Verification required. If audited, the licensee must submit verification of compliance with renewal credit requirements. Licensees are required to keep transcripts of courses taken during the term of the license. Original transcripts and all other documents as required by 282—Chapter 20 must be submitted within 30 calendar days after the date of the audit. An extension of time may be granted on an individual basis.

20.11(2) Results of audit.

a. The board shall notify the licensee of satisfactory completion of the audit by issuing the license.

b. A licensee's failure to complete the audit satisfactorily or falsification of information shall be considered a violation of 282—Chapter 25, Code of Professional Conduct and Ethics, and the executive director may initiate a complaint against the licensee.

c. A licensee's failure to notify the board of a current mailing address will not absolve the licensee from the audit requirement; completion of an audit will be required prior to further license renewal.

282—20.12(272) Appeal procedure. Any teacher seeking a different level of license who is denied the license due to the evaluation or other requirements may appeal the decision. The appeal shall be made in writing to the executive director of the board of educational examiners who shall establish a date for the hearing within 20 days of receipt of written notice of appeal by giving five days' written notice to appellant unless a shorter time is mutually agreeable. The procedures for hearing followed by the board of educational examiners shall be applicable.

282—20.13(272) Licensure renewal programs.

20.13(1) Application process. These rules are to be followed in the preparation and submission of proposals for licensure renewal programs. The application materials must be returned to the board of educational examiners for review and approval. Once the application has been submitted, it will be reviewed, and the applicant agency will be notified of approval or nonapproval and any deficiencies.

20.13(2) Application for licensure renewal program.

a. The application shall contain evidence that the local board of directors (the boards of directors in consortium-based applications) has given formal approval to the development and implementation of the program and the allocation of program resources.

b. The application shall identify the criteria used in selecting faculty/instructors for the licensure renewal programs. These criteria shall include qualifications, experiences (relevant to the nature of the program), preparation and licensure status.

c. There must be evidence of a current survey using multiple data sources that includes, but is not limited to, district and building school improvement goals as well as staff needs and an explanation of

procedures used to derive such needs; this documentation must be furnished as a part of the application for a licensure renewal program.

d. Programs developed by eligible agencies shall be based on evidence gathered from the survey referenced in paragraph “c” above.

e. Program objectives must be derived from identified educational needs in the district or districts or special groups to be served; these objectives shall be developed by the eligible agency seeking approval under licensure renewal programs.

f. Each application must include procedures for program evaluation; this evaluation must include faculty/instructor as well as course/activity evaluation. Program and course/activity evaluation shall include, but not be limited to, participant perceptions.

g. Evaluation. The evaluation shall include participant perception and, whenever possible, observation data collection techniques and analyses are required for each approved licensure renewal program.

20.13(3) Eligible agencies/institutions.

a. Teacher renewal.

(1) Area education agencies, local education agencies, individually or in consortium arrangements.

(2) Approved nonpublic districts, individually or in consortium arrangements.

(3) Iowa educational professional organizations.

(4) Iowa colleges and universities approved for teacher education.

b. Administrator renewal.

(1) Area education agencies, local education agencies, individually or in consortium arrangements.

(2) Approved nonpublic districts, individually or in consortium arrangements.

(3) Iowa educational professional organizations.

(4) Iowa colleges and universities approved for teacher education.

20.13(4) Authority. The acceptance of licensure renewal credit is provided in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272).

20.13(5) Licensure renewal courses.

a. Licensure renewal courses are planned experiences, activities, and studies designed to develop skills, techniques, knowledge, and understanding of educational research and best practice and to model best practices in professional and organizational development. These courses support school improvement processes and practices and provide for the development of leadership in education. Approved courses and programs must be designed to follow the terms of the renewal requirements set forth for teacher and administrator license renewal in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272). The following indicators of quality will be used in evaluating the approved license renewal programs:

(1) The courses address specific student, teacher, and school needs evidenced in local school improvement plans; or

(2) The courses assist teachers in improving student learning; or

(3) The courses assist teachers in improving teaching evidenced through the adoption or application of practices, strategies, and information.

b. Approved teacher licensure renewal programs must offer and conduct a minimum of ten different courses for teachers during the calendar year, and approved administrator licensure renewal programs must conduct a minimum of five different courses for administrators during the calendar year.

c. A minimum of 15 scheduled clock hours of contact with the instructor, study groups or action research teams equal one renewal unit. Only whole units may be submitted to the board of educational examiners for license renewal.

d. Only renewal units offered through board of educational examiners-approved licensure renewal programs will be accepted for license renewal.

20.13(6) Licensure renewal advisory committee. Licensure renewal programs must be developed with the assistance of a licensure renewal advisory committee.

a. Membership of the advisory committee. Once the advisory committee is established, matters pertaining to the term of membership shall be spelled out through established procedures. The advisory

committee shall consist of no fewer than five members. The licensure renewal coordinator shall forward the current updated list of licensure renewal advisory committee members to the board of educational examiners upon request.

(1) The licensure renewal advisory committee shall include the following persons for teacher/administrator renewal programs:

1. Elementary and secondary classroom teachers.
2. Local administrators: elementary or secondary principals, curriculum director or superintendent.
3. Higher education representative from a college or university offering an approved teacher education program.
4. Other categories may also be appointed: community college teaching faculty, students, area education agency staff members, school board members, members of educational professional organizations, business/industry representatives, community representatives, representatives of substitute teachers.

(2) The make-up of the membership should reflect the ratio of teachers to administrators within an agency or organization offering an approved licensure renewal program. The membership should reflect the general population by a balance of gender and race and shall be balanced between urban and rural districts.

(3) The licensure renewal coordinator shall be a nonvoting advisory committee member.

(4) Disputes about the appropriate composition of the membership of the licensure renewal advisory committee shall be resolved through local committee action.

b. Responsibilities of licensure renewal advisory committee. The licensure renewal advisory committee shall be involved in:

- (1) The ongoing area education agency, local district, or other agency staff development needs assessment.
- (2) The design and development of an original application for a license renewal program.
- (3) The development of criteria for the selection of course instructors; and these criteria shall include, but not be limited to, academic preparation, experience and certification status.
- (4) The annual evaluation of licensure renewal programs.

20.13(7) Licensure renewal coordinator.

a. Each agency or organization offering an approved licensure renewal program shall identify a licensed (elementary or secondary) professional staff member who shall be designated as coordinator for the program. This function must be assigned; no application will be approved unless this function has been assigned.

b. Responsibilities of licensure renewal coordinators:

- (1) File all reports as requested by the board of educational examiners.
- (2) Serve as a contact person for the board of educational examiners.
- (3) Be responsible for the development of licensure renewal programs which address the professional growth concerns of the clientele.
- (4) Be responsible for the approval of all courses or units offered for licensure renewal.
- (5) Maintain records of approved courses as conducted and of the names of the qualifying participants.
- (6) Maintain a list of all course offerings and approved instructors and forward the list to the board of educational examiners.
- (7) Provide a record of credit for each participant and maintain a cumulative record of credits earned for each participant for a minimum of ten years.
- (8) Be responsible for informing participants of the reporting procedures for renewal credits/units earned.

20.13(8) Organization and administration.

a. Local school districts are encouraged to work cooperatively with their respective area education agency in assessing needs and designing and conducting courses.

b. The board of educational examiners reserves the right to evaluate any course, to require submission of evaluation data and to conduct sufficient on-site evaluation to ensure high quality of licensure renewal programs.

c. Agencies or institutions developing new programs shall submit a letter of intent prior to the submission of an application. The application must be filed at least three months prior to the initiation of any planned licensure renewal program.

d. Once a program is approved, the coordinator shall approve all course offerings for licensure renewal units.

e. Initial approval may be for one to three years. Continuing approval may be granted for five-year terms. Continuing approval may involve board of educational examiners sponsored team visits.

f. Records retention. Each approved staff development agency/institution shall retain program descriptions, course activities, documentation of the qualifications of delivery personnel, evaluation reports, and completed renewal units for a period of ten years. This information shall be kept on file in the offices of the area education agency licensure renewal coordinators and shall be made available to the board of educational examiners upon request.

g. Monitoring and evaluation. Each approved licensure renewal program will be monitored by the board of educational examiners to determine the extent to which the program meets/continues to meet program standards and is moving toward the attainment of program objectives. This will include an annual report which shall include an annotated description of the courses provided, evidence of the collaborative efforts used in developing the courses, evidence of the intended results of the courses, and the data for demonstrating progress toward the intended results.

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 22
AUTHORIZATIONS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 19]

282—22.1(272) Coaching authorization. A coaching authorization allows an individual to coach any sport in a middle school, junior high school, or high school.

22.1(1) Application process. Any person interested in the coaching authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at www.boee.iowa.gov, or from institutions or agencies offering approved courses or contact hours.

22.1(2) Requirements. Applicants for the coaching authorization shall have completed the following requirements:

a. Content requirements. Requirements completed for semester hour credit must be through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education. Applicants must complete the following content requirements:

(1) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of the structure and function of the human body in relation to physical activity.

(2) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of human growth and development of children and youth in relation to physical activity.

(3) Successful completion of 2 semester credit hours or 20 contact hours in a course relating to knowledge and understanding of the prevention and care of athletic injuries and medical and safety problems relating to physical activity.

(4) Successful completion of 1 semester credit hour or 10 contact hours relating to knowledge and understanding of the techniques and theory of coaching interscholastic athletics.

(5) Beginning on or after July 1, 2000, each applicant for an initial coaching authorization shall have successfully completed 1 semester credit hour or 15 contact hours in a course relating to the theory of coaching which must include at least 5 contact hours relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(6) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

(7) Successful completion of CPR training as verified by a current certificate.

b. Minimum age or diploma. Applicants must have attained a minimum of 18 years. Applicants must also:

(1) Possess a minimum of:

1. A high school diploma,
2. A graduate equivalent diploma, or
3. Home school completion verified by the executive director; or

(2) Be 20 years of age or older.

c. Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

d. License without deficiencies. Applicants who hold a coaching license, certificate, or authorization from at least one other issuing jurisdiction in another state will not be subject to additional coursework if the following requirements have been met:

(1) Verification of Iowa residency in the state of Iowa, or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired equivalent license in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate.

22.1(3) Validity. The coaching authorization shall be valid for five years.

22.1(4) *Renewal.* The authorization may be renewed upon application and verification of successful completion of:

a. Renewal activities. Applicants for renewal of a coaching authorization must:

(1) Successfully complete five planned renewal activities/courses related to athletic coaching approved in accordance with guidelines approved by the board of educational examiners. Additionally, each applicant for the renewal of a coaching authorization shall have completed one renewal activity/course relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(2) Annually complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union. Completion of the concussion training may be waived if the applicant is not serving as a coach. Attendance at the annual concussion training may be used for a maximum of one planned activity/course required in 22.1(4)“a”(1).

(3) Complete child and dependent adult abuse trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4). These trainings combined may be used for a total of one planned activity/course required in 22.1(4)“a”(1).

(4) Provide a current certificate of CPR training.

b. A one-year extension of the applicant’s coaching authorization may be issued if all requirements for the renewal of the coaching authorization have not been met. The applicant must complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union before serving as a coach. The one-year extension is not renewable. The fee for this extension is found in 282—Chapter 12.

22.1(5) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training.

22.1(6) *Approval of courses.* Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the coaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

22.1(7) *Transitional coaching authorization.*

a. *Application process.* Any person interested in the transitional coaching authorization shall submit a complete application verifying the requirements listed below. Application materials are available from the board of educational examiners online at www.boee.iowa.gov.

b. *Requirements.* Applicants for the transitional coaching authorization shall have completed each of the following requirements:

(1) Verification that the applicant has not completed the coursework required for a coaching authorization.

(2) Verification of an offer of a coaching position by a school or a consortium of schools that will additionally verify that:

1. No fully authorized coaching candidates were found after a diligent search,

2. The transitional coach will be supervised by a licensed athletic director, administrator, or other practitioner serving in a supervisory role during the first two weeks of employment, and

3. The supervisor will evaluate the performance of the transitional coach using an evaluation form available on the school’s website.

(3) Successful completion of an approved shortened course of training related to the code of professional rights and responsibilities, practices, and ethics specifically developed for transitional coaches.

(4) Successful completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

(5) Successful completion of a nationally recognized concussion in youth sports training course.

(6) Verification that the applicant has attained a minimum age of 21 years.

(7) Verification of completion of the background check requirements set forth in rule 282—13.1(272).

c. Validity. The transitional coaching authorization shall be valid for no more than one year and shall be valid only in the school or consortium of schools making the offer of the coaching position.

d. Renewal. The transitional coaching authorization is nonrenewable.

e. Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall apply to holders of a transitional coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training. [ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 0866C, IAB 7/24/13, effective 8/28/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 2588C, IAB 6/22/16, effective 7/27/16; ARC 2793C, IAB 11/9/16, effective 12/14/16; see Delay note at end of chapter; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 5321C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.2(272) Substitute authorization. A substitute authorization allows an individual to substitute in grades PK-12 for no more than ten consecutive days in one job assignment for a regularly assigned teacher who is absent, except in the driver's education classroom. A school district administrator may file a written request with the board for an extension of the ten-day limit in one job assignment on the basis of documented need and benefit to the instructional program. The executive director or appointee will review the request and provide a written decision either approving or denying the request.

22.2(1) Application process. Any person interested in the substitute authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at www.boee.iowa.gov or from institutions or agencies offering approved courses or contact hours. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

a. Requirements. Applicants for the substitute authorization shall meet the following requirements:

(1) Authorization program. Applicants must complete a board of educational examiners-approved substitute authorization program consisting of the following components and totaling a minimum of 15 clock hours:

1. Classroom management. This component includes an understanding of individual and group motivation and behavior to create a learning environment that encourages positive social interaction, active engagement in learning, and self-motivation.

2. Strategies for learning. This component includes understanding and using a variety of learning strategies to encourage students' development of critical thinking, problem solving, and performance skills.

3. Diversity. This component includes understanding how students differ in their approaches to learning and creating learning opportunities that are equitable and are adaptable to diverse learners.

4. Ethics. This component includes fostering relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development and to be aware of the board's rules of professional practice and competent performance.

(2) Degree or certificate. Applicants must have achieved a minimum of an associate's degree or 60 semester hours of college coursework.

(3) Minimum age. Applicants must have attained a minimum age of 21 years.

(4) Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

b. Additional requirements. An applicant under this subrule shall be granted a substitute authorization and will not be subject to the authorization program coursework if the following additional requirements have been met:

(1) Verification of Iowa residency or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired substitute authorization in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency license or certificate.

c. Validity. The substitute authorization shall be valid for five years.

d. Renewal. The authorization may be renewed upon application and verification of successful completion of:

(1) Renewal units. Applicants for renewal of the substitute authorization must provide verification of a minimum of two licensure renewal units or semester hours of renewal credits.

(2) Child and dependent adult abuse trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

22.2(2) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the substitute authorization.

22.2(3) Approval of courses. Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the substitute authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 7745B, IAB 5/6/09, effective 6/10/09; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1087C, IAB 10/16/13, effective 11/20/13; ARC 1720C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 2528C, IAB 5/11/16, effective 6/15/16; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 4635C, IAB 8/28/19, effective 10/2/19; ARC 5303C, IAB 12/2/20, effective 1/6/21; see Delay note at end of chapter; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.3(272) School business official authorization.

22.3(1) Application for authorization. Effective July 1, 2012, a person who is interested in a school business official authorization will be required to apply for an authorization.

22.3(2) Responsibilities. A school business official authorization allows an individual to perform, supervise, and be responsible for the overall financial operation of a local school district.

22.3(3) Application process. Any person interested in the school business official authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at www.boee.iowa.gov, or from institutions or agencies offering approved courses or contact hours. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

22.3(4) Specific requirements for an initial school business official authorization. Applicants for an initial school business official authorization shall have completed the following requirements:

a. Education. Applicants must have a minimum of an associate's degree in business or accounting or 60 semester hours of coursework in business or accounting of which 9 semester hours must be in accounting.

If the applicant has not completed 9 semester hours in accounting but has 6 or more semester hours in accounting, the applicant may be issued a temporary school business official authorization valid for one year.

(1) A temporary initial school business official authorization may be issued if requested by the district. A district administrator may file a written request with the executive director for an exception to the minimum content requirements on the basis of documented need and benefit to the district. The executive director will review the request and provide a written decision either approving or denying the request.

(2) If the 9 semester hours of accounting are not completed within the time allowed, the applicant will not be eligible for the initial school business official authorization.

(3) If the applicant received a temporary school business official authorization, then the initial school business official authorization shall not exceed one year.

b. Minimum age. Applicants must have attained a minimum age of 18 years.

c. Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

22.3(5) Specific requirements for a standard school business official authorization.

a. A standard school business official authorization will be valid for three years and may be issued to an applicant who meets the requirements set forth in subrules 22.3(3) to 22.3(5).

b. Requirements.

(1) Applicants must complete 9 semester hours or the equivalent (1 semester hour is equivalent to 15 contact hours) in an approved program in the following areas/competencies:

1. Accounting (GAAP) concepts: fund accounting, account codes, Uniform Financial Accounting.

2. Accounting cycles: budgets, payroll/benefits, purchasing/inventory, cash, receipts, disbursements, financial reporting, investments.

3. Technology: management of accounting systems, proficiency in understanding and use of systems technology and related programs.

4. Regulatory: Uniform Administrative Procedures Manual, school policies and procedures, administrative procedures, public records law, records management, school law, employment law, construction and bidding law.

5. Personal skills: effective communication and interpersonal skills, ethical conduct, information management, ability to analyze and evaluate, ability to recognize and safeguard confidential information, and accurate and timely performance.

(2) Applicants shall demonstrate completion of or competency in the following:

1. A board of educational examiners ethics program.

2. A mentoring program as described in 281—Chapter 81.

3. The promotion of the value of the school business official's fiduciary responsibility to the taxpayer.

22.3(6) Validity.

a. The initial school business official authorization shall be valid for two years.

b. The standard school business official authorization shall be valid for three years.

22.3(7) Renewal. The authorization may be renewed upon application and verification of successful completion of:

a. Renewal activities.

(1) In addition to the child and dependent adult abuse mandatory reporter training listed below, the applicant for renewal must complete 4 semester hours of credit or the equivalent contact hours (1 semester hour is equivalent to 15 contact hours) within the three-year licensure period.

(2) Failure to complete requirements for renewal will require a petition for waiver from the board.

b. Child and dependent adult abuse mandatory reporter trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter trainings pursuant to 282—subrule 20.3(4).

22.3(8) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school business official authorization.

22.3(9) Approval of courses. Each institution of higher education, private college or university, merged area school or area education agency and professional organization that wishes to offer the semester credit hours or contact hours for the school business official authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11; ARC 0869C, IAB 7/24/13, effective 8/28/13; ARC 1719C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.4(272) Licenses—issue dates, corrections, duplicates, and fraud.

22.4(1) Issue date on original authorization. An authorization is valid only from and after the date of issuance.

22.4(2) Correcting authorization. If an applicant notifies board staff of a typographical or clerical error on the authorization within 30 days of the date of the board's mailing of an authorization, a corrected authorization shall be issued without charge to the applicant. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of an authorization, a corrected authorization shall be issued upon receipt of the fee for issuance of a duplicate authorization. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of an authorization, or errors in the type of authorization issued.

22.4(3) Duplicate authorization. Upon application and payment of the fee set out in 282—Chapter 12, a duplicate authorization shall be issued.

22.4(4) Fraud in procurement or renewal of authorization. Fraud in procurement or renewal of an authorization or falsifying records for authorization purposes will constitute grounds for filing a complaint with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11]

282—22.5(272) Preliminary native language teaching authorization.

22.5(1) Authorization. The preliminary native language teaching authorization is provided to noneducators entering the education profession to teach their native language as a foreign language in grades K-6 or grades 7-12.

22.5(2) Application process. Any person interested in the preliminary native language teaching authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov.

22.5(3) Requirements.

a. The applicant must have completed a baccalaureate degree through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

b. Background check. The applicant must complete the background check requirements set forth in rule 282—13.1(272).

c. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher for the position.

d. During the term of the authorization, the applicant must complete board-approved training in the following:

(1) Methods and techniques of teaching. Develop skills to use a variety of learning strategies that encourage students' development of critical thinking, problem solving, and performance skills. The methods course must include specific methods and techniques of teaching a foreign language and must be appropriate for the level of endorsement.

(2) Curriculum development. Develop an understanding of how students differ in their approaches to learning and create learning opportunities that are equitable and adaptable to diverse learners.

(3) Measurement and evaluation of programs and students. Develop skills to use a variety of authentic assessments to measure student progress.

(4) Classroom management. Develop an understanding of individual and group motivation and behavior which creates a learning environment that encourages positive social interactions, active engagement in learning, and self-motivation.

(5) Code of ethics. Develop an understanding of how to foster relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development and become aware of the board's rules of professional practice and code of ethics.

(6) Diversity training for educators. Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society, including preparation that contributes to the education of individuals with disabilities and the gifted and talented.

e. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience in a related subject area.

f. Assessment of native language. The applicant must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board.

22.5(4) Validity. This authorization is valid for three years. No conditional licenses may be issued to applicants holding the preliminary native language teaching authorization. No additional endorsement areas may be added.

22.5(5) Renewal. The authorization is nonrenewable.

22.5(6) Conversion. The preliminary native language teaching authorization may be converted to a native language teaching authorization. The applicant must provide official transcripts verifying the completion of the coursework required in 22.5(3)“d.”

22.5(7) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the preliminary native language teaching authorization. If a school district hires an applicant without a valid preliminary native language teaching authorization, a complaint may be filed against the teacher and the superintendent of the school district.

22.5(8) Approval of courses. Each institution of higher education, private college or university, community college or area education agency wishing to offer the training for the preliminary native language teaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 0562C, IAB 1/23/13, effective 2/27/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.6(272) Native language teaching authorization.

22.6(1) Authorization. The native language teaching authorization allows an individual to teach the individual’s native language as a foreign language in grades K-8 or grades 5-12.

22.6(2) Application process. Any person interested in the native language teaching authorization shall submit an application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov.

22.6(3) Requirements. Applicants must:

a. Hold a preliminary native language teaching authorization and meet the conversion requirements for the native language teaching authorization, or

b. Hold an Iowa teaching license and provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board. Applicants who hold an Iowa teaching license must also obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher with the proper endorsement for the position.

22.6(4) Validity. This authorization is valid for five years. No Class B licenses may be issued to an applicant holding the native language teaching authorization unless a teaching license is additionally obtained. No additional endorsement areas may be added to the native language teaching authorization.

22.6(5) Renewal.

a. Applicants must meet the renewal requirements set forth in rule 282—20.3(272) and 282—subrule 20.5(2).

b. A one-year extension may be issued if all requirements for the renewal of the native language teaching authorization have not been met. This one-year extension is not renewable.

22.6(6) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the native language teaching authorization. If a school district hires an applicant without the proper licensure or endorsement, a complaint may be filed.

[ARC 1721C, IAB 11/12/14, effective 12/17/14]

282—22.7(272) School administration manager authorization.

22.7(1) Application for authorization. Effective July 1, 2014, a person who is interested in a school administration manager authorization will be required to apply for an authorization. The following persons must obtain an authorization:

- a. A Model 1 SAM, a person who is hired to be a full-time SAM and who is authorized to assume the responsibilities of a SAM;
- b. A Model 2 SAM, a person whose position in the school is reconfigured to include the responsibilities of being a SAM and is authorized as a SAM; and
- c. A Model 3 SAM, a person who is a secretary/administrative assistant and is also authorized as a SAM.

22.7(2) Responsibilities. A school administration manager authorization allows an individual to assist a school administrator in performing noninstructional, administrative-type duties.

22.7(3) Application process. Any person interested in the school administration manager authorization shall submit to the board of educational examiners an application which includes a written verification of employment from a school district administrator. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov.

22.7(4) Specific requirements for an initial school administration manager authorization. Applicants for an initial school administration manager authorization shall have completed the following requirements:

- a. *Education.* Applicants must hold a high school degree or general equivalency diploma.
- b. *Minimum age.* Applicants must have attained a minimum age of 18 years.
- c. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

22.7(5) Specific requirements for a standard school administration manager authorization. The initial school administration manager authorization shall be converted to the standard school administration manager authorization provided the following requirements are met.

a. *Training.* A school administration manager shall attend an approved training program at the onset of the individual's hire as a school administration manager. The training for school administration managers is set forth in 281—subrule 82.7(2).

b. *Experience.* An applicant shall complete one year of experience as a school administration manager in an Iowa school. The supervising administrator shall verify this experience and the applicant's completion of the required competencies.

c. *Competencies.* Applicants shall demonstrate completion of or competency in the following:

(1) Each school administration manager shall demonstrate competence in technology appropriate to the school administration manager position. The school administration manager will:

1. Become proficient in the use of the approved time-tracking software tool;
2. Schedule the administrator's time using the approved software, update and reconcile the calendar daily, and attempt to pre-calendar the administrator at or above the administrator's goal; and
3. Regularly schedule, review, and reflect with the administrator on the graphs and data provided through the software.

(2) Each school administration manager shall demonstrate appropriate personal skills. The school administration manager:

1. Is an effective communicator with all stakeholders, including but not limited to colleagues, community members, parents, and students;
 2. Works effectively with employees, students, and stakeholders.
 3. Maintains confidentiality when dealing with student, parent, and staff issues;
 4. Clearly understands the administrator's philosophy of behavior expectations and consequences;
- and
5. Maintains an environment of mutual respect, rapport, and fairness.

22.7(6) Validity.

- a. The initial school administration manager authorization shall be valid for three years.

b. The standard school administration manager authorization shall be valid for five years.

22.7(7) *Renewal.*

a. The initial school administration manager authorization may be renewed once if the applicant has not previously had employment as a school administration manager but can at the time of application provide evidence of employment as a school administration manager.

b. The standard school administration manager authorization may be renewed upon application and verification of successful completion of the following:

(1) *Renewal activities.* The applicant for renewal must complete three semester hours of credit through authorized SAM training or online training courses approved by the board of educational examiners in collaboration with the department of education.

(2) *Child and dependent adult abuse mandatory reporter trainings.* Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter trainings pursuant to 282—subrule 20.3(4).

22.7(8) *Extension.* A one-year extension of the school administration manager authorization may be issued if the applicant does not meet the renewal requirements. The applicant must secure the signature of the superintendent or designee before the extension will be issued.

22.7(9) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school administration manager authorization.

22.7(10) *Approval of courses.* Each institution of higher education, private college or university, community college, area education agency and professional organization that wishes to offer the semester credit hours for the school administration manager authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 1086C, IAB 10/16/13, effective 11/20/13; ARC 1542C, IAB 7/23/14, effective 8/27/14; ARC 1721C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 4634C, IAB 8/28/19, effective 10/2/19]

282—22.8(272) iJAG authorization.

22.8(1) *Authorization.* The Iowa jobs for America’s graduates (iJAG) authorization is provided to noneducators entering the education profession to teach iJAG coursework in grades 7-12.

22.8(2) *Application process.* Any person interested in the iJAG authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov.

22.8(3) *Requirements.*

a. The applicant must have completed a baccalaureate degree.

b. *Background check.* The applicant must complete the background check requirements set forth in rule 282—13.1(272).

c. The applicant must have completed a board of educational examiners-approved iJAG training program consisting of the following components and totaling a minimum of 40 clock hours annually:

(1) *Instructional methods.* Develop skills to effectively deliver project-based instruction in the iJAG core competencies.

(2) *Curriculum.* Develop skills to effectively develop curriculum, projects and other educational opportunities consistent with the goals of iJAG.

(3) *Measurement and evaluation of programs and students.* Analyze student data, administer testing, and monitor the following: basic skills, individualized development plans, attendance, graduation requirements, and course enrollment.

(4) *Code of ethics.* Develop an understanding of how to foster relationships with parents, students, school colleagues, and organizations in the larger community to support students’ learning and development and become aware of the board’s rules of professional practice and code of ethics.

(5) *Diversity training for educators.* Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society,

including preparation that contributes to the education of individuals with disabilities and the gifted and talented.

d. The applicant must obtain a recommendation from an iJAG administrator verifying that the organization wishes to hire the applicant.

e. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience.

22.8(4) *Validity.* This authorization is valid for five years. No Class B license or license based on administrative decision may be issued to an applicant holding the iJAG authorization unless a teaching license is additionally obtained. No additional endorsement areas may be added to the iJAG authorization.

22.8(5) *Renewal.* An applicant for renewal of the iJAG authorization must provide verification of completion of the following:

a. Required iJAG training as verified through an iJAG administrator.

b. Child and dependent adult abuse training as stated in 282—subrule 20.3(4).

22.8(6) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holder of the iJAG authorization.

[ARC 1322C, IAB 2/19/14, effective 3/26/14; ARC 1721C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15]

282—22.9(272) Requirements for the career and technical secondary authorization.

22.9(1) *Authorization.* This authorization is provided to noneducators entering the education profession to instruct in occupations and specialty fields that are recognized in career and technical service areas and career cluster areas.

22.9(2) *Application process.* Any person interested in the career and technical secondary authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

22.9(3) *Specific requirements for the initial career and technical secondary authorization.*

a. The applicant must meet the background check requirements for licensure set forth in rule 282—13.1(272).

b. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant.

c. Applicants shall meet one of the following qualifications:

(1) 6,000 hours of recent and relevant experience;

(2) 4,000 hours of recent and relevant experience if the applicant holds a baccalaureate degree;

(3) 3,000 hours of recent and relevant experience if the applicant holds an associate's degree in the teaching endorsement area sought, if such a degree is considered terminal for that field of instruction;

(4) Hold a baccalaureate or graduate degree or closely related degree in the teaching endorsement area sought; or

(5) Hold a baccalaureate degree in any area of study if at least 18 of the credit hours were completed in the teaching endorsement area sought.

Recent and relevant experience shall have been accrued within the ten years prior to the date of application. Experience that does not meet these criteria may be considered at the discretion of the executive director. In subjects for which state registration, certification or licensure is required, the applicant must hold the appropriate license, registration or certificate before the initial career and technical secondary authorization or the career and technical secondary authorization will be issued.

d. The applicant must provide documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners.

e. Coursework requirements.

(1) Applicants must commit to complete the following requirements within the term of the initial authorization. Coursework must be completed for semester hour credit.

1. Coursework in the methods and techniques of career and technical education.
2. Coursework in course and curriculum development.
3. Coursework in the measurement and evaluation of programs and students.
4. An approved human relations course.
5. Coursework in the instruction of exceptional learners to include the education of individuals with disabilities and the gifted and talented.

(2) Applicants who believe that their previous college coursework meets the coursework requirements in 22.9(3)“e”(1) may have the specific requirements waived. Transcripts or other supporting data should be provided to a teacher educator at one of the institutions which has an approved teacher education program. The results of the competency determination shall be forwarded with recommendations to the board of educational examiners. Board personnel will make final determination as to the competencies mastered and cite coursework which yet needs to be completed, if any.

22.9(4) Validity—initial authorization. The initial career and technical secondary authorization is valid for three years.

22.9(5) Renewal. The initial career and technical secondary authorization may be renewed once if the candidate can demonstrate that coursework progress has been made.

22.9(6) Conversion. The initial career and technical secondary authorization may be converted to a career and technical secondary authorization if the applicant has met the following:

- a. Completion of the required coursework set forth in paragraph 22.9(3)“e.”
- b. Documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners. The training must be completed after the issuance of the initial authorization and no more than three years prior to the date of application.

22.9(7) Specific requirements for the career and technical secondary authorization.

- a. This authorization is valid for five years.
- b. An applicant for this authorization must first meet the requirements for the initial career and technical secondary authorization.
- c. Renewal requirements for the career and technical secondary authorization. Applicants for renewal must meet the requirements set forth in 282—subrule 20.5(1) and 282—paragraphs 20.5(2)“a” to “d.”

22.9(8) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the initial career and technical secondary authorization or the career and technical secondary authorization. If a school district hires an applicant without a valid license or authorization, a complaint may be filed against the teacher and the superintendent of the school district.

[ARC 2015C, IAB 6/10/15, effective 7/15/15; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5323C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.10(272) Activities administration authorization. An activities administration authorization allows an individual to administer any pupil activity program in a K-12 school setting.

22.10(1) Application process. Any person interested in the activities administration authorization shall submit an application and records of credit to the board of educational examiners for an evaluation of the required courses or contact hours. Application materials are available from the office of the board of educational examiners online at www.boee.iowa.gov. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

a. *Requirements.* Applicants for the activities administration authorization shall meet the following requirements:

- (1) Degree. A baccalaureate degree or higher in athletic administration or related field is required.

(2) Credit hours. Applicants must complete credit hours or courses offered by the Leadership Training Institute (LTI) from the National Interscholastic Athletic Administrators Association in the following areas:

1. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of risk management, Title IX, sexual harassment, hazing, Americans with Disabilities Act (ADA), and employment law as they pertain to the role of the activities administrator.

2. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of activities administration foundations including philosophy, leadership, professional programs and activities administration principles, strategies and methods.

3. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the role of the activities director in supporting and developing sports medicine programs, management of athletic player equipment, concussion assessment and proper fitting of athletic protective equipment, and sports field safety.

4. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the techniques and theory of coaching concepts and strategies for interscholastic budget and concepts and strategies for interscholastic fundraising.

5. Successful completion of 1 semester credit hour or LTI course, approved by the board, relating to the assessment and evaluation of interscholastic athletic programs and personnel, dealing with challenging personalities, and administration of professional growth programs for interscholastic personnel.

6. Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

b. Minimum age. Applicants must have attained a minimum age of 21 years.

c. Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

22.10(2) Validity. The activities administration authorization shall be valid for five years.

22.10(3) Renewal.

a. The authorization may be renewed upon application and verification of successful completion of the following renewal activities:

(1) Applicants for renewal of an activities administration authorization must complete one of the following professional development options:

1. Document attendance at one state IHSADA convention and one LTI course relating to the knowledge and understanding of professional ethics and legal responsibilities of activities administrators.

2. Complete three LTI courses.

3. Complete 2 semester hours of college credit.

4. Complete 2 licensure renewal credits from an approved provider.

(2) Applicants for renewal of an activities administration authorization must complete child and dependent adult abuse training as stated in 282—subrule 20.3(4).

b. A one-year extension of the applicant's activities administration authorization may be issued if all requirements for the renewal of the activities administrator authorization have not been met. The one-year extension is nonrenewable.

22.10(4) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the activities administration authorization. [ARC 1718C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—22.11(272) Extension. For authorizations established in this chapter, a one-year extension may be issued if the applicant does not meet the requirements for authorization conversion or renewal. The applicant shall secure the signature of the superintendent or designee of the applicant's employer and shall submit all required materials before the extension will be issued. This one-year extension is nonrenewable.

This rule is intended to implement Iowa Code section 272.31. [ARC 2121C, IAB 9/2/15, effective 10/7/15]

282—22.12(272) Orientation and mobility authorization.

22.12(1) Authorization. The holder of this authorization may teach pupils with a visual impairment (see Iowa Code section 256B.2), including those pupils who are deaf-blind.

22.12(2) Initial orientation and mobility authorization. The initial authorization is valid for three years. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education. An applicant must:

- a. Hold a baccalaureate or master's degree from an approved state program in orientation and mobility or equivalent coursework.
- b. Have completed an approved human relations component.
- c. Have completed the exceptional learner program, which must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.
- d. Have completed a minimum of 21 semester credit hours in the following areas:
 - (1) Medical aspects of blindness and visual impairment, including sensory motor.
 - (2) Psychosocial aspects of blindness and visual impairment.
 - (3) Child development.
 - (4) Concept development.
 - (5) History of orientation and mobility.
 - (6) Foundations of orientation and mobility.
 - (7) Orientation and mobility instructional methods and assessments.
 - (8) Techniques of orientation and mobility.
 - (9) Research or evidence-based practices in orientation and mobility.
 - (10) Professional issues in orientation and mobility, including legal issues.
- e. Have completed at least 350 hours of fieldwork and training under the supervision of the university program.
- f. Have completed the background check requirements set forth in rule 282—13.1(272).

22.12(3) Standard orientation and mobility license. An applicant must:

- a. Complete the requirements set forth in subrule 22.12(2).
- b. Verify successful completion of a three-year probationary period.

22.12(4) Renewal of orientation and mobility license. Applicants must meet the renewal requirements set forth in rule 282—20.3(272) and 282—subrule 20.5(2).

22.12(5) Exception. An orientation and mobility specialist is not eligible for any administrator license in either general education or special education.

[ARC 5322C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code chapter 272.

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¹ December 14, 2016, effective date of 22.1(2)“a”(7) and 22.1(4)“a”(4) [ARC 2793C, Item 2] delayed until the adjournment of the 2017 General Assembly by the Administrative Rules Review Committee at its meeting held December 13, 2016.

² January 6, 2021, effective date of 22.2 [ARC 5303C, Item 2] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 24
PARAEDUCATOR CERTIFICATES
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 22]

282—24.1(272) Paraeducator certificates. Iowa paraeducator certificates are issued upon application filed on a form provided by the board of educational examiners. Applicants must complete the background check requirements set forth in rule 282—13.1(272).
[ARC 2230C, IAB 11/11/15, effective 12/16/15]

282—24.2(272) Approved paraeducator certificate programs. An applicant for an initial paraeducator certificate who completes the paraeducator preparation program from a recognized Iowa paraeducator approved program shall have the recommendation from the designated certifying official at the recognized area education agency, local education agency, community college, or institution of higher education where the preparation was completed. A recognized Iowa paraeducator approved program is one which has its program of preparation approved by the state board of education according to standards established by the board of educational examiners.

282—24.3(272) Prekindergarten through grade 12 paraeducator generalist certificate.

24.3(1) Applicants must possess a minimum of a high school diploma or a graduate equivalent diploma.

24.3(2) Qualifications or criteria for the granting or revocation of a certificate or the determination of an individual's professional standing shall not include membership or nonmembership in any teacher or paraeducator organization.

24.3(3) Applicants shall have successfully completed at least 90 clock hours of training in the areas of behavior management, exceptional child and at-risk child behavior, collaboration skills, interpersonal relations skills, child and youth development, technology, and ethical responsibilities and behavior.

24.3(4) Applicants shall have successfully completed the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Recognize the different developmental stages of students.
- (2) Believe every student can learn.
- (3) Recognize that each learner has unique learning needs that may require accommodations.
- (4) Demonstrate knowledge of the common core, including competence in reading, writing and math.

(5) Function in a manner that demonstrates a positive regard for the distinction between roles and responsibilities of paraeducators and other professionals, including respecting the teacher as supervisor and seeing the teacher as ultimately responsible for the education and behavior of the students.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

(1) Follow the prescribed health, safety, and emergency school and classroom policy and procedures.

(2) Organize materials to support teaching and learning.

(3) Facilitate the integration of students with diverse needs in various settings.

(4) Assist with special health services, under the supervision of a licensed health care provider.

(5) Promote a safe and positive learning environment.

(6) Function in various instructional settings (e.g., large group, small group, tutoring).

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

(1) Assist with learning activities and opportunities to accomplish instructional objectives.

(2) Support high expectations that are shared, clearly defined and appropriate.

(3) Monitor progress and document and report objective observations that inform instructional decisions.

(4) Effectively use verbal and nonverbal forms of communication with students.

(5) Assist with the implementation and use of instructional and assistive technology.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Assist in modeling and teaching specific appropriate behaviors, social skills, and procedures that facilitate safety and learning in various environments.
- (2) Assist in the implementation of individualized behavior management plans.
- (3) Document and report objective observations on student behaviors.
- (4) Assist in modifying the learning environment to manage behavior and social skills.
- (5) Recognize that there is a cause or reason for misbehavior and assist in determining the cause or reason.
- (6) Recognize, address, and report bullying.
- (7) Recognize and report atypical emotional behavior.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Demonstrate a commitment to work as an effective team member.
- (2) Foster a professional and caring relationship with each student's family.
- (3) Develop and maintain positive and professional relationships with students.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Follow ethical practices for confidential information.
- (2) Participate in ongoing professional development.
- (3) Accept and apply constructive feedback.
- (4) Abide by the Iowa code of ethics and professional practice rules of the board of educational examiners and rules of the Iowa department of education.
- (5) Demonstrate the ability to separate personal issues from one's responsibilities in the workplace.
- (6) Maintain a high level of competency and integrity.
- (7) Share information regarding students' performance, behavior, or program with students' parents or guardians only as directed by the supervising teacher or educator.
- (8) Be aware of personal biases and beliefs and refrain from discriminatory practices based on a student's disability, race, creed, color, religion, age, sex, sexual orientation, gender identity, disability, marital status, or national origin.
- (9) Demonstrate ethical behavior when supporting students with graded activities, quizzes, and tests.
- (10) Abide by Iowa law regarding the use of restraint and seclusion.
- (11) Recognize that the paraeducator may not be given primary responsibility for the education of an individual student(s).
- (12) Recognize that instructional decisions are made by the individualized education program (IEP) team for students with disabilities and that any changes to instruction, accommodations, supports, and services cannot be made outside the IEP team.

24.3(5) An applicant for a certificate under these rules shall demonstrate that the requirements of the certificate have been met, and the burden of proof shall be on the applicant.

[ARC 1325C, IAB 2/19/14, effective 3/26/14]

282—24.4(272) Paraeducator area of concentration. An area of concentration is not required but optional. Applicants must currently hold or have previously held an Iowa paraeducator generalist certificate. Applicants may complete one or more areas of concentration but must complete at least 45 clock hours in each area of concentration, with the exception of the substitute authorization.

24.4(1) Early childhood—prekindergarten through grade 3. The paraeducator shall successfully complete the following list of competencies:

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Know and understand young children's typical and atypical developmental stages and their needs at each stage.
- (2) Recognize multiple influences on young children's development and learning.

(3) Recognize developmentally appropriate practices for interactions with and the education of young children.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Describe the elements of environments that support children's learning and well-being.
- (2) Demonstrate skills, strategies, and activities involving an individual child or small groups of children to reinforce instruction from a licensed teacher.
- (3) Set up environments that are safe, inclusive, and responsive to children's developmental strengths, interests and needs.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Recognize effective strategies and techniques to stimulate cognitive, physical, social, emotional, and language development for each child in a developmentally appropriate way.
- (2) Demonstrate knowledge and understanding of the Iowa Early Learning Standards by describing what young children know and do in order to provide experiences and interactions to promote learning.
- (3) Gather information, as instructed by the classroom teacher, about an individual child's development, learning and behaviors including observing, recording, and charting.

d. Emotional and behavioral competencies. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Gather information, as instructed by the classroom teacher, to identify children's skills and provide appropriate levels of support needed for the children to access, participate and engage in activities.
- (2) Implement teacher-designed intervention plans to promote positive social relationships, interactions and behaviors that are age- and developmentally appropriate.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Demonstrate the ability to collaborate with an educational team to systematically and regularly exchange information to support problem solving, planning, and the implementing of instruction and individualized interventions.
- (2) Demonstrate the ability to establish relationships with all children and their families that are respectful, supportive and sensitive.
- (3) Demonstrate a collaborative relationship with the teacher to support children's learning.
- (4) Demonstrate knowledge of community services and agencies available to assist families.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Demonstrate knowledge of Iowa Early Learning Standards and the preschool program standards being implemented, which may include the Iowa Quality Preschool Program Standards, Head Start Program Performance Standards and National Association for the Education of Young Children (NAEYC) Program Standards and Accreditation Criteria.
- (2) Reserved.

24.4(2) Special needs—prekindergarten through grade 12. The paraeducator shall successfully complete the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of an IEP.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of the value of serving children and youth with disabilities and special needs in inclusive settings.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Implement the activities assigned by a teacher to meet the goals and objectives in an IEP.
- (2) Assist in academic subjects through use of lesson plans and instructional strategies developed by teachers and other professional support staff.

(3) Gather and maintain data about the performance of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(4) Operate computers and use assistive technology and adaptive equipment that will enable students with special needs to participate more fully in general education.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

(1) Gather and maintain data about the behavior of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(2) Use appropriate instructional procedures and reinforcement techniques as specified in the IEP or by the behavior team.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will, if asked, participate as a member of the IEP team responsible for developing service plans and educational objectives.

24.4(3) English as a second language—prekindergarten through grade 12. The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Operate computers and use technology that will enable students to participate effectively in the classroom.

b. Work with the classroom teacher as collaborative partners.

c. Demonstrate knowledge of the role and use of primary language of instruction in accessing English for academic purposes.

d. Demonstrate knowledge of instructional methodologies for second language acquisition.

e. Communicate and work effectively with parents or guardians of English as a second language students in their primary language.

f. Demonstrate knowledge of appropriate translation and interpretation procedures.

24.4(4) Career and transitional programs—grades 5 through 12. The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Assist in the implementation of career and transitional programs.

b. Assist in the implementation of appropriate behavior management strategies for career and transitional students and those students who may have special needs.

c. Assist in the implementation of assigned performance and behavior assessments including observation, recording, and charting for career and transitional students and those students who may have special needs.

d. Provide training at job sites using appropriate instructional interventions.

e. Participate in preemployment, employment, or transitional training in classrooms or at off-campus sites.

f. Communicate effectively with employers and employees at work sites and with personnel or members of the public in other transitional learning environments.

24.4(5) School library media—prekindergarten through grade 12. The school library media paraeducator shall successfully complete the following list of competencies so that, under the direct supervision and direction of a qualified school library supervisor or school librarian, the paraeducator will be able to:

a. Be aware of, implement, and support the goals, objectives, and policies of the school library media program.

b. Assist the school library supervisor or school librarian in general operations, such as processing materials, circulating materials, performing clerical tasks, assisting students and staff, and working with volunteers and student helpers, and to understand the role of the paraeducator in the library setting in order to provide efficient, equitable, and effective library services.

c. Demonstrate knowledge of library technical services including, but not limited to, cataloging, processing, acquisitions, routine library maintenance, automation and new technologies.

- d. Be aware of and support the integration of literacy initiatives and content area standards, e.g., visual information and technology in support of the curriculum.
- e. Be aware of the role school libraries play in improving student achievement, literacy, and lifelong learning.
- f. Demonstrate an understanding of ethical issues related to school libraries, such as copyright, plagiarism, privacy, diversity, confidentiality, and freedom of speech.
- g. Assist in the daily operations of the school library program, such as shelving, working with volunteers and student helpers, inventory, materials repair and maintenance.
- h. Exhibit welcoming behaviors to all library patrons and visitors to encourage use of the library and its resources.
- i. Demonstrate knowledge of the school library collection and the availability of other resources that will meet individual student information or research needs.
- j. Demonstrate a general knowledge of basic technology skills and assist in troubleshooting basic hardware and software problems.

24.4(6) *Speech-language pathology (SLP)—prekindergarten through grade 12.* The speech-language pathology paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified speech-language pathologist, the paraeducator will be able to:

- a. Understand the roles and responsibilities of the speech-language pathology paraeducator.
- b. Demonstrate a basic understanding of the four areas of communication, including articulation, language, fluency, and voice, and how they occur through typical development.
- c. Demonstrate an understanding of articulation/phonological disabilities.
- d. Demonstrate an understanding of language disabilities.
- e. Use appropriate instructional procedures and reinforcement techniques when working with children with articulation/phonological disabilities.
- f. Use appropriate instructional procedures and reinforcement techniques when working with children with language disabilities.
- g. Gather information as directed by the speech-language pathologist regarding the performance of children, including recording and charting responses.

24.4(7) *Vision impairments—prekindergarten through grade 12.*

- a. Demonstrate knowledge of the impact of vision loss on learning and concept development for students who are blind or visually impaired.
 - (1) Demonstrate introductory knowledge of expanded core curriculum (ECC) and the ability to support ECC skills as directed by the supervising professional.
 - (2) Demonstrate introductory knowledge of functional vision assessments (FVA) and learning media assessments (LMA) of students who have vision impairments.
- b. Demonstrate knowledge of and skills in technology appropriate to the needs of students with vision impairments.
 - (1) Operate and use assistive technology that supports students who have vision impairments.
 - (2) Support and strengthen each student's capability to access and utilize assistive technology.
- c. Demonstrate introductory knowledge of instructional strategies unique to students who have vision impairments.
 - (1) Demonstrate the ability to adapt educational materials by using varied learning media as determined by student needs.
 - (2) Demonstrate an introductory knowledge of Braille in relation to identified or expressed student needs or both.
 - (3) Demonstrate introductory skills in operating transcription software and equipment.
- d. Demonstrate introductory knowledge of motor skills, movement, orientation, and mobility for students with vision impairments.
- e. Demonstrate knowledge of the role of paraeducators in student plans including individualized education programs (IEPs) and individualized family service plans (IFSPs).

f. Demonstrate knowledge about and skills in fostering independence, self-determination, social skills, self-advocacy, and appropriate behaviors for students with vision impairments.

g. Demonstrate professionalism and ethical practices, including appropriate communication skills in relation to students with vision impairments and the students' service providers and families.

24.4(8) Autism spectrum disorders. Under the direction and supervision of a qualified classroom teacher, the paraeducator shall successfully complete the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate an understanding of the components of education plans (individualized education program (IEP), behavior intervention plan (BIP), functional behavioral analysis (FBA), and Section 504 Plan).

(2) Identify common characteristics of students with autism spectrum disorder (communication, social, restricted interest and behavior) and how these characteristics compare to those of typical children.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

(1) Assist in structuring the environment to meet the needs of students with autism spectrum disorder.

(2) Implement with integrity schedules and educational programs prescribed by the licensed teacher.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

(1) Implement the educational, academic, and communication accommodations, adaptations, and supports assigned by a teacher.

(2) Provide opportunities for students with autism spectrum disorders to initiate and respond to large interactions and small interactions in academic settings.

(3) Provide opportunities for students with autism spectrum disorders to initiate, respond to, and participate in interactions in large groups and small groups in authentic situations.

(4) Gather and maintain data on student academic performance as directed by a licensed teacher.

(5) Assist educational staff in developing accommodations and adaptations and self-determination skills to increase student independence.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

(1) Understand and identify the function of a behavior (e.g., antecedents, behaviors, consequences).

(2) Collect data on student behavior and related environmental stimuli, based on the concepts of antecedents, behaviors and consequences.

(3) Implement antecedent strategies on student behavior, as defined by the licensed educator.

(4) Reinforce and practice replacement behaviors, as defined by the licensed educator.

(5) Respond to problem behaviors in a consistent manner, as defined by the licensed educator.

(6) Gather and maintain data on student social and behavioral performance, as directed by a licensed teacher.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate the ability to support the viewpoints and perspectives of students with autism and be empathetic to the students' learning styles.

(2) Respond to challenging behaviors in a respectful, empathetic manner.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

(1) Know and understand the expectations of confidentiality in regard to student information and social media usage.

(2) Know and understand the legal constructs of the IEP and the Individuals with Disabilities Education Act (IDEA).

24.4(9) Paraeducator substitute authorization. An individual who holds a paraeducator certificate and completes the substitute authorization requirements set forth in rule 282—22.2(272) but who does

not meet the degree requirement in subparagraph 22.2(1) “a”(2) is authorized to substitute only in the special education classroom in which the individual paraeducator is employed.

[ARC 8405B, IAB 12/16/09, effective 1/20/10; ARC 9204B, IAB 11/3/10, effective 12/8/10; ARC 1325C, IAB 2/19/14, effective 3/26/14; ARC 2529C, IAB 5/11/16, effective 6/15/16; ARC 3197C, IAB 7/5/17, effective 8/9/17; ARC 5303C, IAB 12/2/20, effective 1/6/21; see Delay note at end of chapter]

282—24.5(272) Prekindergarten through grade 12 advanced paraeducator certificate. Applicants for the prekindergarten through grade 12 advanced paraeducator certificate shall have met the following requirements:

24.5(1) Currently hold or have previously held an Iowa paraeducator generalist certificate.

24.5(2) Possess an associate’s degree or have earned 62 semester hours of college coursework. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

24.5(3) Complete a minimum of 2 semester hours of coursework involving at least 100 clock hours of a supervised practicum with children and youth. These 2 semester hours of practicum may be part of an associate’s degree or part of the earned 62 semester hours of college coursework.

[ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—24.6(272) Renewal requirements.

24.6(1) The paraeducator certificate may be renewed upon application, payment of a renewal fee as established in 282—Chapter 12, and verification of successful completion of coursework totaling three units in any combination listed below.

a. One unit may be earned for each semester hour of credit which leads to the completion of the requirements for an area of concentration not currently held.

b. One unit may be earned for each hour of credit that will assist a paraeducator to demonstrate the knowledge of and the ability to assist in reading, writing, or mathematics.

c. One unit may be earned for each hour of credit completed which supports either the building’s or district’s career development plan.

d. One unit may be earned for each semester hour of college credit.

24.6(2) All applicants renewing a paraeducator certificate must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

[ARC 4634C, IAB 8/28/19, effective 10/2/19]

282—24.7(272) Issue date on original certificate. A certificate is valid only from and after the date of issuance.

282—24.8(272) Validity. The paraeducator certificate shall be valid for five years.

282—24.9(272) Certificate application fee. All fees are nonrefundable.

24.9(1) Issuance of certificates. The fee for the issuance of the paraeducator certificate shall be as established in 282—Chapter 12.

24.9(2) Adding areas of concentration. The fee for the addition of each area of concentration to a paraeducator certificate, following the issuance of the initial paraeducator certificate and any area(s) of concentration, shall be as established in 282—Chapter 12.

These rules are intended to implement Iowa Code chapter 272.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

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[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

¹ January 6, 2021, effective date of 24.4 [ARC 5303C, Item 3] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 27
ISSUANCE OF PROFESSIONAL SERVICE LICENSES

282—27.1(272) Professional service license. A professional service licensee is an individual prepared to provide professional services in Iowa schools but whose preparation has not required completion of the teacher preparation coursework set forth in rule 281—79.15(256). Degrees and coursework shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education. The professional service license may be issued in the following areas but does not permit service as a teacher:

1. School counselor.
2. School psychologist.
3. Speech-language pathologist.
4. Supervisor of special education (support).
5. Director of special education of an area education agency.
6. School social worker.
7. School audiologist.

[ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—27.2(272) Requirements for a professional service license.

27.2(1) Initial professional service license. An initial professional service license valid for a minimum of two years with an expiration date of June 30 may be issued to an applicant for licensure to serve as a school audiologist, school psychologist, school social worker, speech-language pathologist, supervisor of special education (support), director of special education of an area education agency, or school counselor who:

- a. Has a master's degree in a recognized professional educational service area.
- b. Has completed a state-approved program which meets the requirements for an endorsement in a professional educational service area.
- c. Has completed the requirements for one of the professional educational service area endorsements.
- d. Meets the recency requirement of 282—subparagraph 13.5(2) "b"(4).
- e. Completes the background check requirements set forth in rule 282—13.1(272).

27.2(2) Standard professional service license. A standard professional service license valid for five years may be issued to an applicant who:

- a. Completes requirements listed under 27.2(1) "a" to "d."
- b. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa standards as determined by a comprehensive evaluation and two years' successful service experience in an Iowa public school. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful service area experience in an Iowa nonpublic school or three years' successful service area experience in an out-of-state K-12 educational setting.
- c. Meets the recency requirement of 282—subparagraph 13.5(2) "b"(4).

27.2(3) Renewal. Renewal requirements for this license are set out in 282—Chapter 20.

27.2(4) Professional service exchange license.

a. For an applicant applying under rule 282—27.1(272), a two-year nonrenewable exchange license may be issued to the applicant if the applicant has met at least 75 percent of the minimum coursework requirements for licensure but has some coursework deficiencies. At any time during the term of the exchange license, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

b. An applicant under this section shall be granted an Iowa professional service license and will not be subject to coursework deficiencies if the following additional requirements have been met:

- (1) Verification of Iowa residency, or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired equivalent license in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate. Endorsements shall be granted based on comparable Iowa endorsements, and endorsement requirements may be waived in order to grant the most comparable endorsement.

27.2(5) Class G license. A nonrenewable Class G license valid for one year may be issued to an individual who must complete a school counseling practicum or internship in an approved program in preparation for the professional school counselor endorsement. The Class G license may be issued under the following limited conditions:

- a. Verification of a baccalaureate degree.
 - b. Verification from the institution that the individual is admitted and enrolled in a school counseling program.
 - c. Verification that the individual has completed the coursework and competencies required prior to the practicum or internship.
 - d. Written documentation of the requirements listed in paragraphs 27.2(5) “a” to “c,” provided by the official at the institution where the individual is completing the approved school counseling program and forwarded to the Iowa board of educational examiners with the application form for licensure.
- [ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3979C, IAB 8/29/18, effective 10/3/18; ARC 5321C, IAB 12/16/20, effective 1/20/21; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—27.3(272) Specific requirements for professional service license endorsements.

27.3(1) Elementary professional school counselor.

a. *Authorization.* The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. *Program requirements.*

- (1) Master’s degree from an accredited institution of higher education.
- (2) Completion of an approved human relations component.
- (3) Completion of an approved exceptional learner component.

c. *Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

- (1) The competencies listed in 282—subparagraphs 13.28(26) “c”(1) to (11).
- (2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26) “c”(12).

27.3(2) Secondary professional school counselor.

a. *Authorization.* The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in grades five through twelve.

b. *Program requirements.*

- (1) Master’s degree from an accredited institution of higher education.
- (2) Completion of an approved human relations component.
- (3) Completion of an approved exceptional learner component.

c. *Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

- (1) The competencies listed in 282—subparagraphs 13.28(26) “c”(1) to (11).
- (2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26) “c”(12).

27.3(3) School psychologist.

a. *Authorization.* The holder of this endorsement is authorized to serve as a school psychologist with pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant shall have completed a program of graduate study that is currently approved (or that was approved at the time of graduation) by the National Association of School Psychologists or the American Psychological Association, or be certified as a Nationally Certified School Psychologist by the National Association of School Psychologists, in preparation for service as a school psychologist through one of the following options:

1. Completion of a master's degree with sufficient graduate semester hours beyond a baccalaureate degree to total 60; or

2. Completion of a specialist's degree of at least 60 graduate semester hours with or without completion of a terminal master's degree program; or

3. Completion of a doctoral degree program of at least 60 graduate semester hours with or without completion of a terminal master's degree program or specialist's degree program.

(2) The program shall include an approved human relations component.

(3) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

c. School psychologist one-year Class A license.

(1) Requirements for a one-year Class A license. A nonrenewable Class A license valid for one year may be issued to an individual who must complete an internship or thesis as an aspect of an approved program in preparation for the school psychologist endorsement. The one-year Class A license may be issued under the following limited conditions:

1. Verification from the institution that the internship or thesis is a requirement for successful completion of the program.

2. Verification that the employment situation will be satisfactory for the internship experience.

3. Verification from the institution of the length of the approved and planned internship or the anticipated completion date of the thesis.

4. Verification of the evaluation processes for successful completion of the internship or thesis.

5. Verification that the internship or thesis is the only requirement remaining for successful completion of the approved program.

(2) Written documentation of the above requirements must be provided by the official at the institution where the individual is completing the approved school psychologist program and forwarded to the board of educational examiners with the application form for licensure.

27.3(4) Speech-language pathologist. A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a speech-language pathologist to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant must hold a master's degree in speech pathology.

(2) Content. An applicant must have completed the requirements in speech pathology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school speech-language pathologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:

1. Curriculum courses (e.g., reading, methods, curriculum development).

2. Foundations (e.g., philosophy of education, foundations of education).

3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).

4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).

5. Courses in special education (e.g., introduction to special education, learning disabilities).

6. Child development courses (e.g., human growth and development, principles and theories of child development, history and theories of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

(3) The applicant must complete an approved human relations component.

(4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

27.3(5) Professional service administrator.

a. Authorization. The holder of this endorsement is authorized to serve as a supervisor of special education support programs. However, an individual holding a statement of professional recognition is not eligible for the professional service administrator endorsement.

b. Program requirements.

(1) An applicant must hold a master's degree in preparation for school psychology, speech/language pathology, audiology (or education of students who are deaf or hard of hearing), or social work.

(2) Content. The program shall include a minimum of 16 graduate semester hours to specifically include the following:

1. Consultation process in special or regular education.
2. Current issues in special education administration including school law/special education law.
3. Program evaluation.
4. Educational leadership.
5. Administration and supervision of special education.
6. Practicum: Special education administration. NOTE: This requirement may be waived based on two years of experience as a special education administrator.
7. School personnel administration.
8. Evaluator approval component.

c. Other. The applicant must:

(1) Have four years of support service in a school setting with special education students in the specific discipline area desired.

(2) Meet the practitioner licensure requirements of one of the following endorsements:

1. School audiologist (or deaf or hard of hearing at K-8 and 5-12).
2. School psychologist.
3. School social worker.
4. Speech-language pathologist.

27.3(6) Director of special education of an area education agency.

a. Authorization. The holder of this endorsement is authorized to serve as a director of special education of an area education agency. Assistant directors are also required to hold this endorsement. However, an individual holding a statement of professional recognition is not eligible for the director of special education of an area education agency endorsement.

b. Program requirements.

(1) Degree—specialist or its equivalent. An applicant must hold a master's degree plus at least 32 semester hours of planned graduate study in administration or special education beyond the master's degree.

(2) Endorsement. An applicant must hold or meet the requirements for one of the following:

1. PK-12 principal and PK-12 supervisor of special education (see rule 282—18.9(272));
2. Supervisor of special education—instructional (see rule 282—15.5(272));
3. Professional service administrator (see subrule 27.3(5)); or
4. A letter of authorization for special education supervisor issued prior to October 1, 1988.

(3) Content. An applicant must have completed a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements to include the following:

1. Knowledge of federal, state and local fiscal policies related to education.
2. Knowledge of school plant/facility planning.

3. Knowledge of human resources management, including recruitment, personnel assistance and development, evaluations, and negotiations.

4. Knowledge of models, theories and philosophies that provide the basis for educational systems.

5. Knowledge of current issues in special education.

6. Knowledge of special education school law and legislative and public policy issues affecting children and families.

7. Knowledge of the powers and duties of the director of special education of an area education agency as delineated in Iowa Code section 273.5.

8. Practicum in administration and supervision of special education programs.

(4) Experience. An applicant must have three years of administrative experience as a PK-12 principal or PK-12 supervisor of special education.

(5) Competencies. Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, the director of special education accomplishes the following:

1. Facilitates the development, articulation, implementation and stewardship of a vision of learning that is shared and supported by the school community.

2. Advocates, nurtures and sustains a school culture and instructional program conducive to student learning and staff professional growth.

3. Ensures management of the organization, operations and resources for a safe, efficient and effective learning environment.

4. Collaborates with educational staff, families and community members; responds to diverse community interests and needs; and mobilizes community resources.

5. Acts with integrity and fairness and in an ethical manner.

6. Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.

7. Collaborates and assists in supporting integrated work of the entire agency.

c. *Other.*

(1) Option 1: Instructional. An applicant must meet the requirements for one special education teaching endorsement and have three years of teaching experience in special education.

(2) Option 2: Support. An applicant must meet the practitioner licensure requirements for one of the following endorsements and have three years of experience as a:

1. School audiologist;

2. School psychologist;

3. School social worker; or

4. Speech-language pathologist.

27.3(7) School social worker. A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. *Authorization.* An individual who meets the requirements of 282—subrule 16.6(2) is authorized to serve as a school social worker to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. *Endorsement requirements.* An applicant must hold a master's degree in social work from an accredited school of social work to include a minimum of 20 semester hours of coursework (including practicum experience) which demonstrates skills, knowledge, and competencies in the following areas:

(1) Social work.

1. Assessment (e.g., social, emotional, behavioral, and familial).

2. Intervention (e.g., individual, group, and family counseling).

3. Related studies (e.g., community resource coordination, multidiscipline teaming, organizational behavior, and research).

(2) Education.

1. General education (e.g., school law, foundations of education, methods, psychoeducational measurement, behavior management, child development).

2. Special education (e.g., exceptional children, psychoeducational measurement, behavior management, special education regulations, counseling school-age children).

(3) Practicum experience. A practicum experience in a school setting under the supervision of an experienced school social work practitioner is required. The practicum shall include experiences that lead to the development of professional identity and the disciplined use of self. These experiences will include: assessment, direct services to children and families, consultation, staffing, community liaison and documentation. If a person has served two years as a school social worker, the practicum experience can be waived.

(4) Completion of an approved human relations component is required.

(5) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

27.3(8) School audiologist. A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a school audiologist to pupils from birth to age 21 who are deaf or hard of hearing (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant must hold a master's degree in audiology.

(2) Content. An applicant must complete the requirements in audiology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school audiologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:

1. Curriculum courses (e.g., reading, methods, curriculum development).

2. Foundations (e.g., philosophy of education, foundations of education).

3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).

4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).

5. Courses in special education (e.g., introduction to special education, learning disabilities).

6. Child development courses (e.g., human growth and development, principles and theories of child development, history of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

(3) An applicant must complete an approved human relations component.

(4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

[ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 9074B, IAB 9/8/10, effective 10/13/10; ARC 9076B, IAB 9/8/10, effective 10/13/10; ARC 1328C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2397C, IAB 2/17/16, effective 3/23/16; ARC 5322C, IAB 12/16/20, effective 1/20/21; ARC 5802C, IAB 7/28/21, effective 9/1/21]

282—27.4(272) Specific renewal requirements for the initial professional service license.

27.4(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

27.4(2) If a person meets all requirements for the standard professional service license except for the requirements in paragraph 27.2(2) “b,” the initial professional service license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the requirements in paragraph 27.2(2) “b” and if the license holder can provide evidence of employment which will be acceptable for the experience requirement.

[ARC 8609B, IAB 3/10/10, effective 4/14/10]

282—27.5(272) Specific renewal requirements for the standard professional service license.

27.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth in rule 282—20.3(272).

27.5(2) Four units are needed for renewal. For an applicant who also holds a specialist's or doctor's degree, two units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved pursuant to guidelines established by the board of educational examiners.

[ARC 8609B, IAB 3/10/10, effective 4/14/10; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—27.6(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

27.6(1) *Endorsement in progress.* The individual has a valid professional service license and one or more professional service endorsements, but is seeking to obtain some other professional service endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other professional service endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement.

27.6(2) *Request for exception.* A school district administrator may file a written request with the board for an exception to the minimum content requirements on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

27.6(3) *Expiration.* This license will expire on June 30 of the fiscal year in which it was issued plus one year.

[ARC 8959B, IAB 7/28/10, effective 9/1/10]

282—27.7(272) Timely renewal. A license may only be renewed less than one year before it expires.

[ARC 9452B, IAB 4/6/11, effective 5/11/11]

These rules are intended to implement Iowa Code chapter 272.

[Filed ARC 7980B (Notice ARC 7743B, IAB 5/6/09), IAB 7/29/09, effective 9/2/09]

[Filed ARC 8609B (Notice ARC 8410B, IAB 12/30/09), IAB 3/10/10, effective 4/14/10]

[Filed ARC 8959B (Notice ARC 8689B, IAB 4/7/10), IAB 7/28/10, effective 9/1/10]

[Filed ARC 9074B (Notice ARC 8829B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]

[Filed ARC 9076B (Notice ARC 8831B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]

[Filed ARC 9452B (Notice ARC 9301B, IAB 12/29/10), IAB 4/6/11, effective 5/11/11]

[Filed ARC 1328C (Notice ARC 1236C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]

[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]

[Filed ARC 2397C (Notice ARC 2237C, IAB 11/11/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 3633C (Notice ARC 3471C, IAB 12/6/17), IAB 2/14/18, effective 3/21/18]

[Filed ARC 3829C (Notice ARC 3710C, IAB 3/28/18), IAB 6/6/18, effective 7/11/18]

[Filed ARC 3979C (Notice ARC 3827C, IAB 6/6/18), IAB 8/29/18, effective 10/3/18]

[Notice of Intended Action ARC 5212C, IAB 12/16/20]

[Notice of Intended Action ARC 5216C, IAB 12/16/20]

[Filed ARC 5321C, IAB 12/16/20, effective 1/20/21]

[Filed ARC 5322C, IAB 12/16/20, effective 1/20/21]

[Filed ARC 5802C (Notice ARC 5666C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498],
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization
numbering scheme in general, IAC Supp. 2/11/87.

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

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

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

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7. [ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

“Adverse benefit determination” means any adverse action taken as to any individual’s benefits pursuant to an assistance program administered by the department or on the department’s behalf, excluding determinations related to requests for exceptions to policy.

“Appeals section” means the director’s designee who is charged with administering the department’s appeals.

“Appellant” means a person, including an authorized representative acting on the person’s behalf, seeking to appeal some action pursuant to this chapter.

“Assistance program” means a program administered by the department or on the department’s behalf through which qualifying individuals receive benefits or services. Assistance programs include, but are not necessarily limited to, the Supplemental Nutrition Assistance Program (SNAP), Medicaid, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, the family self-sufficiency grant, PROMISE JOBS, state supplementary assistance, the healthy and well kids in Iowa (hawki) program, foster care, adoption, and aftercare services.

“Authorized representative” means a person lawfully designated by an individual to act on the individual’s behalf or who has legal authority to act on behalf of the individual.

“Contested case” refers to an evidentiary hearing mandated by state or federal constitutional or statutory authority whereupon a presiding officer makes a determination pertaining to the relative rights and obligations of parties to an appeal under this chapter.

“Department” means the Iowa department of human services.

“DIA” means the Iowa department of inspections and appeals and may include presiding officers where appropriate.

“Director” means the director of the department or the director’s designee.

“Enrollee” means any applicant to or recipient of benefits or services pursuant to an assistance program.

“Good cause” means an intervening cause, not attributable to the negligence of a party, reasonably resulting in a delay or failure to attend, for purposes of subrules 7.4(3) and 7.9(2).

“Intentional program violation” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Supplemental Nutrition Assistance Program (SNAP), SNAP regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of SNAP benefits or an electronic benefit transfer (EBT) card. An intentional program violation is determined through a SNAP administrative disqualification hearing, a court conviction, or when an individual signs and returns Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Managed care organization” or *“MCO”* has the meaning assigned to it in rule 441—73.1(249A) and includes prepaid ambulatory health plans.

“Medicaid” means Iowa’s medical assistance program administered under Iowa Code chapter 249A.

“Party-in-interest” refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.

“*Presiding officer*” means an administrative law judge charged with the administration and adjudication of the contested case hearing process for a particular appeal.

“*Self-represented*” means representing oneself without an attorney.
[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 5810C, IAB 7/28/21, effective 9/1/21]

441—7.2(17A) Governing law and regulations. In the absence of an applicable rule in this chapter, the DIA rules found at 481—Chapter 10 govern department appeals. Notwithstanding the foregoing and the rules contained in this chapter, to the extent that federal or state law (including regulations and rules) related to a specific program is more specific than or contradicts these rules or the applicable DIA rules, the program-specific federal or state law shall control. For example, Supplemental Nutrition Assistance Program (SNAP) appeals shall be conducted in accordance with 7 CFR 273.15 and 7 CFR 273.16, and medical assistance appeals shall be conducted in accordance with 42 CFR Part 431, subpart E, and Part 438, subpart F.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 5810C, IAB 7/28/21, effective 9/1/21]

DIVISION I
GENERAL APPEALS PROCESS

441—7.3(17A) When a contested case hearing will be granted.

7.3(1) Requirements. A person shall be granted a contested case hearing if the party-in-interest fulfills all of the following requirements:

- a. The party-in-interest is entitled to a contested case hearing;
- b. The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and
- c. The party-in-interest meets all of the other requirements contained in these rules.

7.3(2) Contractual rights not subject to contested case hearing. Unless otherwise provided by law, when an appellant seeks a contested case hearing of an issue predicated upon or governed by the terms of a contract between appellant and another party, including the department, a contested case hearing shall not be provided.

7.3(3) Change in law. A contested case hearing shall not be granted when the sole issue raised is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries to an assistance program.

7.3(4) Competitive procurement bid appeals. Competitive procurement bid appeals shall be adjudicated pursuant to Division II of this chapter.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.4(17A) Initiating an appeal.

7.4(1) Exhaustion of remedies. An appellant shall only be granted a contested case hearing if the appellant has exhausted all other appeal remedies available to the party-in-interest. An appellant should refer to program-specific provisions for the appropriate procedures applicable to specific programs.

7.4(2) Medicaid managed care enrollees exhaustion of remedies.

a. A Medicaid managed care enrollee shall be granted a contested case hearing only if the enrollee has either received a decision from a managed care organization in the time and manner required by rule 441—73.12(249A) or has been deemed to have exhausted the managed care organization appeals under paragraph 7.4(2)“b.”

b. If a Medicaid enrollee’s managed care organization fails to provide a decision in the time and manner required by rule 441—73.12(249A), the enrollee shall be deemed to have exhausted the managed care organization’s appeals process and may initiate a contested case hearing.

7.4(3) Time to appeal. For a contested case hearing to be granted, the following timelines must be met:

a. *Supplemental Nutrition Assistance Program (SNAP), Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, family planning program and autism support program.* For appeals pertaining to Supplemental Nutrition Assistance Program (SNAP), Medicaid

eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, the family planning program or the autism support program, the appellant must appeal on or before the ninetieth day following the date of notice of an adverse benefit determination.

b. Managed care organization medical coverage. For appeals pertaining to medical services coverage under Medicaid managed care, the appellant must appeal on or before the one hundred twentieth day following the date of exhaustion, actual or deemed, of the managed care organization appeal process outlined in rule 441—73.12(249A).

c. Tax offsets. Except for counties appealing an offset under 441—Chapter 14, for appeals of state or federal tax offsets, the appellant must appeal on or before the fifteenth day following the date of notice of the action. For counties appealing a debtor offset under 441—Chapter 14, the county must appeal on or before the thirtieth day following the date of notice of the offset.

d. Iowa individual disaster assistance program. For appeals pertaining to the Iowa individual disaster assistance program, the appellant must appeal on or before the fifteenth day following the date of the department's reconsideration decision, pursuant to 441—subrule 58.7(1).

e. Iowa disaster case management program. For appeals pertaining to the Iowa disaster case management program, the appellant must appeal on or before the fifteenth day following the date of the department's reconsideration decision, pursuant to 441—subrule 58.7(1).

f. Dependent adult abuse. For appeals regarding dependent adult abuse, the appellant must appeal within six months of the date of notice of the action as provided in Iowa Code section 235B.10.

g. Child abuse. For appeals regarding child abuse, the person alleged responsible for the abuse must appeal on or before the ninetieth day following the date of notice of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the appeal on or before the tenth day following the date of notice of the right to intervene.

h. Sex offender risk assessment. For appeals regarding a sex offender risk assessment, the appellant must appeal in writing on or before the fourteenth day following the date of notice.

i. Assistance program overpayments. For appeals pertaining to the family investment program, refugee cash assistance, PROMISE JOBS, child care assistance, medical assistance, healthy and well kids in Iowa (hawki), family planning program or Supplemental Nutrition Assistance Program (SNAP) overpayments, the party-in-interest's right to appeal the existence, computation and amount of the overissuance or overpayment begins when the department sends the first notice informing the party-in-interest of the overissuance or overpayment.

j. All other appeals. For all other appeals, and unless federal or state law provides otherwise elsewhere, the appellant must appeal on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, of the date of notice, the director or director's designee may, at the director's or designee's sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the appellant.

7.4(4) Written and oral notification. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance.

(1) The right to request a hearing.

(2) The procedure for requesting a hearing.

(3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

b. Written notification shall be given on the application form and all notices of decision.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 5810C, IAB 7/28/21, effective 9/1/21]

441—7.5(17A) How to request an appeal.

7.5(1) Ways to request a hearing. An appellant may request a contested case hearing:

a. Via the department's website,

b. By telephone, except as specified in subrule 7.5(4),

- c. By mail,
- d. In person, except as specified in subrule 7.5(4), or
- e. Through other commonly available electronic means (such as email or facsimile).

7.5(2) Hearing request. The request for a contested case hearing must be sufficiently detailed so that the department can reasonably understand the action being appealed. The department may request additional information to determine the scope of the appeal. The department may deny if there is not sufficient information to determine the action being appealed.

7.5(3) Filing date. The date of filing for appeal requests sent by regular mail shall be the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the agency. The date of filing for appeal requests sent electronically shall be determined by the date on which the electronic submission was completed.

7.5(4) Appeals that must be filed in writing. Appeal requests pertaining to foster care, adoption, state supplementary assistance, the autism support program, the Iowa individual disaster assistance program, the Iowa disaster case management program, sex offender risk assessment, record check evaluation, child care registered or nonregistered homes, child abuse, dependent adult abuse or child support must be made in writing.

7.5(5) Department's responsibilities. Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt of an appeal request, forward Form 470-0487 or 470-0487(S), Appeal and Request for Hearing; the written appeal; the postmarked envelope, if there is one; and a copy of the notification of the proposed adverse action to the appeals section.

b. Within ten days of the receipt of the appeal, forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section. When practicable, the summary may also include suggested relevant legal authorities.

c. Copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal are to be provided to the appellant at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.6(17A) Prehearing procedures.

7.6(1) Acknowledgment of appeal. When the appeals section receives a request for appeal, it shall send acknowledgment of the receipt of the appeal to the parties to the appeal. For appeals regarding child abuse, all subjects other than the person alleged responsible (party-in-interest) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

7.6(2) Acceptance or denial of appeal. The appeals section will determine with reasonable promptness whether the party-in-interest is entitled to a contested case hearing under rule 441—7.3(17A). If a request is accepted, the appeals section will certify the appeal to DIA and designate the issues on appeal pursuant to subrule 7.6(3). If a request for a contested case hearing is denied, the appeals section will provide written notice of and the reasons for the denial. On or before the thirtieth day following the denial, the individual requesting the appeal may provide additional information related to the individual's asserted right to a contested case hearing and request reconsideration of the denial.

7.6(3) Designation of issues for appeal.

a. *Initial designation.* After determining that the party-in-interest is entitled to a contested case hearing, the appeals section will designate the issues to be decided at the contested case hearing. The issues identified may include all issues raised by the appellant and may also include additional issues identified by the appeals section. The issues designated shall be certified to DIA and be identified in the notice of hearing issued pursuant to subrule 7.6(5).

b. *Additional designation of issues.* If any party believes additional issues should be designated, on or before the tenth day following the date of the notice of hearing, the party shall identify those additional issues. The presiding officer shall determine whether all issues have properly been preserved.

If the hearing is within ten days of the date of the notice of hearing, the party shall identify any additional issues at the hearing.

7.6(4) Group hearings regarding medical assistance. The appeals section may respond to a series of related, individual requests for hearings regarding medical assistance by consolidating individual hearings into a single group hearing where the sole issue is based on state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.6(5) Notice of hearing.

a. Issuance of hearing notice. Except as provided in paragraph 7.6(5) “b,” DIA shall send notice to the parties of the appeal at least ten calendar days in advance of the hearing setting forth the date, time, method, and place of the hearing; that evidence may be presented orally or documented to establish pertinent facts; that the parties may bring and question witnesses and refute testimony; and that the parties may be represented by others, including an attorney, at the parties’ own cost and as subject to state and federal law. Notice shall be mailed by first-class mail, postage prepaid, and addressed to the appellant at the appellant’s last-known address.

b. Intentional program violation hearing notices. DIA shall send notices of hearing regarding alleged intentional program violations at least 30 days in advance of the hearing date. The notices under this paragraph shall otherwise comply with the requirements of paragraph 7.6(5) “a.”

7.6(6) Appellant’s right to department’s case file. Prior to and during the contested case hearing, the department must provide enrollees or their authorized representative with the opportunity to examine the content of the appellant’s case file, if any, and all documents and records to be used by the department at the hearing.

7.6(7) Informal conference. The purpose of an informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action or position, and to provide an opportunity for the appellant to examine the contents of the case record.

a. When requested by the appellant, an informal conference with a representative of the department or one of its contracted partners, including a managed care organization, shall be held as soon as possible after the appeal has been filed. An appellant’s representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

b. An informal conference need not be requested for the appellant to examine the contents of the case record.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.7(17A) Timelines for contested case hearings.

7.7(1) Medical assistance. In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR 431.244(f).

7.7(2) Community spouse resource allowance. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

7.7(3) Sex offender risk assessment. In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.8(17A) Contested case hearing procedures.

7.8(1) Method. Contested case hearings may be conducted via telephone or videoconference. Upon request of a party to the appeal or order of the presiding officer, the contested case hearing shall be conducted in person.

7.8(2) Evidence.

a. The parties to a contested case hearing shall be permitted to:

- (1) Bring witnesses,
- (2) Submit competent evidence to establish all pertinent facts and circumstances,
- (3) Present arguments without undue interference,

- (4) Question or refute any testimony or evidence, including through cross-examination, and
- (5) Respond to evidence and arguments on all issues.

b. Evidence shall be received or excluded as provided in Iowa Code section 17A.14.

7.8(3) *Right to counsel.* Parties to an appeal shall be permitted to be represented by counsel at the parties' own expense.

7.8(4) *Self-represented appellants.* The presiding officer shall, at the officer's discretion, provide reasonable assistance to self-represented appellants. The presiding officer must, however, ensure that such assistance does not impact the independence and fairness of the contested case hearing process.

7.8(5) *Closed to public.* Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

7.8(6) *Administration of appeals.* Except as otherwise provided in this chapter or other applicable federal or state law, discretion in the conduct and administration of appeals is vested in the contested case hearing presiding officer.

7.8(7) *Contested cases with no factual dispute.* If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.9(17A) Miscellaneous rules governing contested case hearings.

7.9(1) *Ex parte communication.* Ex parte communications between the presiding officer and person or party in connection with any issue of fact or law in the contested case proceeding is prohibited except as permitted by Iowa Code section 17A.17. All of the provisions of Iowa Code section 17A.17 apply.

7.9(2) *Default.* If a party fails to appear at a scheduled hearing or prehearing conference without good cause as determined by the presiding officer, the party's appeals may be denied and dismissed or may be heard and ruled upon, consistent with Iowa Code section 17A.12. Defaulting parties may file a timely motion to vacate, which shall be granted if the presiding officer determines good cause has been shown.

7.9(3) *Withdrawal.* An appellant may submit a withdrawal of a fair hearing request at any time prior to hearing through any of the methods identified in subrule 7.5(1), except for programs listed in subrule 7.5(4). For programs listed in subrule 7.5(4), a written request may be submitted via the department's website, by mail, in person, or through other commonly available electronic means (such as email or facsimile). Unless otherwise provided, a withdrawal shall be with prejudice.

7.9(4) *Medical assessment.* For Medicaid enrollees engaged in an appeal involving medical issues, the department may request, at the department's own expense, that the appellant submit to an appropriate medical assessment. The presiding officer shall order such assessment upon sufficient showing of necessity.

7.9(5) *Interpreters.* The department shall provide translation and interpretation services to appellants not fluent in English. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when an appellant is illiterate or semiliterate, the presiding officer shall advise the appellant of the appellant's rights to the satisfaction of the appellant's understanding.

7.9(6) *Persons living with disabilities.* Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.10(17A) Proposed decision.

7.10(1) *Contents.* The presiding officer shall issue a written proposed decision to all parties clearly identifying the issues on appeal, holding, findings of fact, conclusions of law, and order. The findings of fact shall cite and be based exclusively on the record as defined by Iowa Code section 17A.12(6). The

conclusions of law shall be limited to the contested issues of fact, policy or law and shall identify the specific provisions of law that support the ultimate conclusion.

7.10(2) Access to record. After receiving the proposed decision, appellants shall be given reasonable access to the record at a convenient place and time.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.11(17A) Director's review.

7.11(1) Time. Parties, including the department, may appeal the proposed decision to the director.

a. A request for director's review shall be in writing and postmarked or received within ten calendar days of the date on which the proposed decision was issued, except as provided for under paragraph 7.11(1) "b." A request for director's review may be accompanied by a brief written summary of the arguments in favor of director's review.

b. A managed care organization appealing a proposed decision reversing an adverse benefit determination shall request director's review within 72 hours from the date it received notice of the proposed decision.

7.11(2) Grant or denial of review. The department has full discretion to grant or deny a request for review. In addition, the director may initiate review of a proposed decision on the director's own motion at any time on or before the tenth day following the issuance of the proposed decision.

When the department grants a request for director's review, the appeals section shall notify the parties to the appeal of the review request and enclose a copy of the request. All other parties shall have ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

7.11(3) Cross-appeal. When a party requests director's review in accordance with subrule 7.11(1), the remaining parties shall have ten calendar days from that date to submit cross-requests for director's review. The party originally seeking director's review shall have ten calendar days from the date of the cross-request for director's review to submit further written arguments or objections for consideration upon review.

7.11(4) Limited record. Director's review shall be limited to the issues and record before the contested case hearing presiding officer.

7.11(5) Oral arguments. Upon specific request, the director may, at the director's discretion, permit parties to present oral arguments with the parties' requests for director's review.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.12(17A) Final decisions.

7.12(1) No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the presiding officer's proposed decision becomes the final decision of the agency.

7.12(2) Timelines.

a. The department or director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the department or director will issue a final decision on or before the ninetieth day from the date the department receives an appeal request.

b. Except as otherwise provided by state or federal law, the time frames for a final decision provided under this rule may be tolled when:

- (1) The appellant requests a delay;
- (2) The appellant fails to take a required action; or
- (3) There is an administrative or other emergency beyond the department's control.

c. DIA shall document in the record the reasons for any delay and the requesting party.

7.12(3) Written notice of final decision. The parties to the appeal shall be provided written notice of the department's final decision. The department shall also notify the appellant of the appellant's right to seek judicial review, where applicable.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.13(17A) Expedited review.

7.13(1) Expedited review criteria. Appellants to a medical assistance appeal may, at any time, file with the department a request for expedited review of the appeal. Expedited review shall be granted when the department determines, or a provider acting on behalf or in support of an appellant indicates, that taking the time for a standard resolution could seriously jeopardize the party-in-interest's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

7.13(2) Managed care expedited proceedings.

a. If the appellant is granted an expedited review pursuant to subrule 73.12(2), all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the managed care organization appeal was expedited and provides the basis for expedited relief.

b. When review is expedited pursuant to paragraph 7.13(2) "a," the presiding officer shall issue a proposed decision as expeditiously as the enrollee's health condition requires, but no later than three working days after the department receives from the managed care organization the case file and information for any appeal of a denial of a service that, as indicated by the managed care organization:

(1) Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or

(2) Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

7.13(3) Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review expedited proceedings. For expedited appeals related to Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than seven working days after the department receives a request for expedited fair hearing.

7.13(4) Medicaid-covered benefits or services expedited proceedings. For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than provided in paragraph 7.13(2) "b."

7.13(5) Final decision for expedited proceeding. The department shall issue its final decision in accordance with this rule, except as provided by subrule 7.12(2).

7.13(6) Notification if expedited relief is granted or denied. The department shall notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice must be provided orally or through electronic means to the extent consistent with federal and state law. If oral notice is provided, the department shall follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.14(17A) Effect.

7.14(1) If the contested case hearing presiding officer's proposed decision is favorable to an enrollee in a Medicaid appeal, the department must promptly make corrective payments retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility. If the presiding officer reverses a decision of a managed care organization to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date the managed care organization receives notice reversing the determination.

7.14(2) Unless there is contravening federal or state law, all final decisions shall be put into effect within seven days of the issuance of the final decision.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.15(17A) Calculating time. In computing any time period specified in this chapter, the period:

1. Excludes the day of the event that triggers the period;
2. Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and

3. Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.16(17A) Authorized representatives.

7.16(1) Regulations. The provisions of this rule only apply to the extent the standards expressed in this rule are not in conflict with other state or federal law.

7.16(2) Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for an individual in an appeal under this chapter shall provide a written, signed designation of authority to the department with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

7.16(3) Written designation. For persons seeking to act as authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative's written designation of authority pursuant to subrule 7.16(2) shall be Form 470-5526, Authorized Representative for Managed Care Appeals.

7.16(4) Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance identifying the legal counsel.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.17(17A) Continuation and reinstatement of benefits.

7.17(1) Programs for which no federal or state law applies. For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:

- a. An appeal is filed before the effective date of the intended action; or
- b. The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period.

7.17(2) Sole issue is state or federal law or policy. Benefits or services continued pursuant to subrule 7.17(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the department has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

7.17(3) Recoup cost of services or benefits. The department or managed care organization may recoup the cost of benefits or services provided pursuant to this chapter if the adverse action appealed from is affirmed, consistent with state and federal law.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.18(17A) Emergency adjudicative proceedings.

7.18(1) Necessary emergency action. When and to the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with state and federal law, a contested case hearing presiding officer may issue a written order to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. In determining the necessity of such an action, the presiding officer shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;
- b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;
- c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and
- e. Whether the specific action contemplated is necessary to avoid the immediate danger.

7.18(2) Issuance of order. An emergency adjudicative order shall contain, or shall be expeditiously followed by, a written analysis, including findings of fact, conclusions of law, and policy reasons to justify the order. The agency shall provide written notice that best ensures prompt, reliable delivery. Such order shall be immediately delivered to the persons required to comply with the order.

7.18(3) Completion of proceedings. Upon issuance of an order under this rule, the department shall proceed as quickly as reasonably practicable to complete any proceedings that would be required if the matter did not involve an immediate danger. An order issued under this rule shall include notice of the date on which proceedings under this chapter are to be completed. After issuance of an order under this rule, continuance of further proceedings under this chapter shall only be granted in compelling circumstances upon application in writing. Before issuing an emergency adjudicative order, the presiding officer shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;
- b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;
- c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and
- e. Whether the specific action contemplated is necessary to avoid the immediate danger.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.19(17A) Supplemental Nutrition Assistance Program (SNAP) administrative disqualification hearings. The department acts on alleged intentional program violations either through an administrative disqualification hearing or referral to a court of appropriate jurisdiction. An individual accused of an intentional program violation may waive the individual's right to an administrative disqualification hearing in accordance with the procedures outlined in this rule and in 7 CFR 273.16(e) and (f).

7.19(1) When a case is referred for an administrative disqualification hearing, the appeals section shall mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

7.19(2) By signing Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, the individual:

- a. Waives the right to an administrative disqualification hearing;
- b. Consents to the SNAP disqualification period designated on Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, and a reduction of benefits for the period of disqualification; and
- c. Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

7.19(3) An administrative disqualification hearing shall be scheduled if the individual does not sign and mail or fax Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, to the appeals section within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification, unless the individual shows the notification was not received within the five-day period.

7.19(4) An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

7.19(5) No further administrative appeal procedure exists after an individual waives the individual's right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty shall not be changed by a subsequent fair hearing decision.

[ARC 5810C, IAB 7/28/21, effective 9/1/21]

441—7.20 to 7.40 Reserved.

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope, bidder and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process. A bidder is an entity that submits a proposal in response to a solicitation issued through the department of human services' competitive procurement process.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the department's decision.

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, email, or in-person delivery.

When an appeal is submitted through an electronic delivery method, such as electronic mail or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method or the appeal was filed via in-person delivery, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

7.43(1) *Hearing time frame.* The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

7.43(2) *Registration.* Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) *Acknowledgment.* Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

7.43(4) *Granting a hearing.* The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to the appellant and the appellant's representative advising of the denial of the hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial may present additional information relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.8(17A).

7.43(7) *Reschedule requests.* Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.43(8) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.44(17A) Procedures for bidder appeal.

7.44(1) *Discovery.* The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) *Witnesses and exhibits.* The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) *Amendments to notice of appeal.* The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

7.44(4) *Hearing not conducted in person.* If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

7.44(5) *Decision.* The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case

and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

7.44(6) The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) Stay of agency action for bidder appeal.

7.45(1) *When a stay may be requested.*

a. Any party appealing the issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

b. Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

7.45(2) *When a stay is granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

7.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) Request for review of the proposed decision. A request for review of the proposed decision shall follow the provisions outlined in rule 441—7.11(17A).

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3787C, IAB 5/9/18, effective 7/1/18; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.47(17A) Other procedural considerations.

7.47(1) *Consolidation—severance.*

a. Consolidation. The presiding officer may, upon motion by any party or the presiding officer’s own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues; and
- (3) Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

b. Severance. The presiding officer may, upon motion by any party or upon the presiding officer’s own motion, for good cause shown, order any proceeding or portion thereof severed.

7.47(2) *Presiding officer.* Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals.

7.47(3) *Rights of appellants during hearings.* All rights afforded appellants at rule 441—7.8(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in Iowa Code section 17A.16.

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) *Petition.* When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

7.49(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications specified in subrule 7.9(1) and Iowa Code section 17A.17 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review specified in subrule 7.12(3) and Iowa Code section 17A.19 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code chapter 17A.

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◊ Two or more ARCs

TITLE VIII
MEDICAL ASSISTANCE
CHAPTER 73
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding.

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.

441—73.1(249A) Definitions.

“Behavioral health services” means mental health and substance use disorder treatment services.

“Capitated payment” means a monthly payment to the contractor on behalf of each enrollee for the provision of health services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

“Choice counseling” means the provision of unbiased information on managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

“Claim” means a formal request for payment for benefits received or services rendered.

“Clean claim” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

“CMS” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“Code of Federal Regulations (CFR)” means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

“Community-based case management” means a collaborative process of planning, facilitation, and advocacy for options and services to meet a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

“Contract” means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

“Covered services” means physical health, behavioral health and long-term care services set forth in rule 441—73.5(249A).

“Department” means the Iowa department of human services.

“Discharge planning” means the process, which begins at admission, of determining an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

“Electronic visit verification system” means, with respect to personal care services or home health care services defined in Section 12006 of the 21st Century Cures Act, a system under which visits conducted as part of such services are electronically verified with respect to: (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service begins and ends.

“Emergency medical condition” means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

“EMTALA” means the Emergency Medical Treatment and Active Labor Act.

“Enrollee” means a hawki, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

“Enrollment broker” means the entity the department uses to enroll persons in a managed care organization. The enrollment broker must be conflict free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to October 16, 2015.

“Hawki program” means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

“Health maintenance organization” means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

“HIP” means the health insurance premium payment program.

“Home- and community-based services (HCBS)” means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

“Incident reporting” means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

“Insolvency” means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business or when the liabilities of the entity exceed its assets.

“Iowa Health and Wellness Plan” means the medical assistance program set forth in 441—Chapter 74.

“Level of care” means an evaluation to determine and establish an individual’s need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future.

“Long-term care (LTC)” or *“long-term services and supports (LTSS)”* means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID),

state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

“Managed care organization (MCO)” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“Mandatory enrollment” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“Medical loss ratio (MLR)” means the percentage of capitation payments that is used to pay medical expenses.

“Medically necessary services” means those covered services that are, under the terms and conditions of the contract, determined through contractor utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member’s physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

“Medical records” means all medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“Member” means any person determined by the department to be eligible for the hawki program, the Iowa Health and Wellness Plan, or the Medicaid program.

“Money Follows the Person (MFP) Rebalancing Demonstration Grant” means a federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

“Needs-based eligibility” means an evaluation to determine and establish an individual’s need for habilitation services.

“Network” or *“provider network”* means a group of participating health care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health care services.

“Out-of-network provider” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

“PACE” means the program for all-inclusive care for the elderly.

“Participating providers” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

“Passive enrollment process” means the process by which the department assigns a member to a managed care organization and which, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care organizations.

“PMIC” means a psychiatric medical institution for children.

“Prior authorization” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“*Warm transfer*” means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—73.2(249A) Contracts with a managed care organization.

73.2(1) The department may enter into a contract with a managed care organization licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as defined in rule 441—73.6(249A).

73.2(2) The department shall determine that the managed care organization meets the following requirements:

a. The managed care organization shall make available the services it provides to enrollees as established in the contract.

b. The managed care organization shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the managed care organization’s debts if the managed care organization becomes insolvent. The managed care organization shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

73.2(3) If not already accredited, the managed care organization must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the managed care organization must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with insurance division rules set forth in 191—Chapter 40.

73.2(4) The contract shall meet the following minimum requirements. The contract shall:

a. Be in writing.

b. Specify the duration of the contract period.

c. List the services which must be covered.

d. Describe service access and provide access information.

e. List conditions for nonrenewal, termination, suspension, and modification.

f. Specify the method and rate of reimbursement.

g. Provide for disclosure of ownership and subcontracted relationships.

h. Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the managed care organization, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

i. Specify appeal and grievance rights.

j. Specify all operational and service delivery expectations.

k. Specify reporting requirements.

l. Specify requirements for utilization management and quality improvement.

m. Specify requirements for program integrity.

n. Specify termination requirements and assessment of penalties.

o. Require managed care organizations and the fee-for-service Medicaid program to utilize a uniform prior authorization process. The process will include forms, information requirements, and time frames.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4847C, IAB 1/1/20, effective 6/29/20]

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All hawki program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid

members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

- a. Members who are medically needy as defined at 441—subrule 75.1(35).
- b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).
- c. Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).
- d. Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).
- e. Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).
- f. Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).
- g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

73.3(3) Enrollment process. The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to May 6, 2016.

a. *General.* Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. *Passive assignment.* Effective no earlier than the first day of the month of the member's application to Medicaid, the member shall be assigned to a managed care organization using the department's passive enrollment process and offered the opportunity to choose from the available managed care organizations within a time frame specified in the passive assignment letter.

c. *Request to change enrollment.* An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

d. *Ongoing enrollment.* Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

e. *Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

73.3(4) Benefit reimbursement prior to enrollment.

a. Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(4) "b," the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

b. The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods prior to the effective date of enrollment for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4429C, IAB 5/8/19, effective 7/1/19]

441—73.4(249A) Disenrollment process.

73.4(1) Enrollee-requested disenrollment. An enrollee may request disenrollment with a managed care organization as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The managed care organization does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment shall be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the hawki program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

d. The department has determined that participation in the HIPPP program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care organization-requested disenrollment.* A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.* The effective date of a department-approved disenrollment shall be no later than the first day of the second calendar month beginning after the month in which: (1) the enrollee requests disenrollment pursuant to subrule 73.4(1); (2) the department notifies the enrollee and managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the managed care organization shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.5(249A) Covered services.

73.5(1) Required services. A managed care organization shall provide:

a. For enrollees other than Iowa Health and Wellness Plan enrollees and hawki program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

- (1) Area education agency services.
- (2) Dental services not provided in an outpatient hospital setting.
- (3) Infant and toddler program services.
- (4) Local education agency services.
- (5) State of Iowa Veterans Home services.
- (6) Money Follows the Person Grant-funded services.

b. Services as set forth in 441—Chapter 74 for Iowa Health and Wellness Plan enrollees.

c. Services as set forth in 441—Chapter 86 for hawki program enrollees.

73.5(2) Community-based case management service. The managed care organization is required to provide services that meet requirements specified in the contract and in 441—Chapter 90.

73.5(3) Health home services. The managed care organization is required to provide services that meet the requirements specified in 441—subrule 78.53(1) and as specified in the contract.

73.5(4) Value-added services. A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, psychiatric medical institutions for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

73.6(2) The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The managed care organization shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, 7 days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

a. Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.

b. Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination, as defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

73.7(3) The managed care organization shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

b. Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.8(249A) Access to service.

73.8(1) The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, 7-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the managed care organization's provider network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

73.8(3) Continuity of care. The managed care organization shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The managed care organization shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. Member helpline. The managed care organization shall maintain a dedicated toll-free member services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal managed care organization departments, such as to care coordinators.

b. Nurse call line. The managed care organization shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, 7 days a week from trained medical professionals.

73.8(5) An enrollee's primary care provider shall be responsible for providing preventative and primary health care to the enrollee; for initiating referrals for specialist care, where appropriate; and for maintaining the continuity of patient care. Primary care providers may be physicians, advanced

registered nurse practitioners, or physician assistants, licensed and practicing in accordance with state law.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 4392C, IAB 4/10/19, effective 6/1/19]

441—73.9(249A) Incident reporting. The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.10(249A) Discharge planning. The managed care organization shall establish policies and procedures, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.11(249A) Level of care assessment and annual reviews. The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

73.11(1) Initial level of care assessment. Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(2) Annual continued stay reviews, continued care reviews and redeterminations. When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the IME medical services unit for determination of level of care or needs-based eligibility.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.12(249A) Appeal of managed care organization actions. The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

73.12(1) Managed care organization appealable actions. Managed care organization actions that may be appealed include:

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.
- f. For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

73.12(2) Appeal process. The managed care organization appeal process shall be approved by the department and shall:

- a. Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.
- b. Require acknowledgment of the receipt of a request for an appeal within three working days.
- c. Allow for participation by the enrollee and the provider.
- d. Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.
- e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.
- f. Ensure that the review will be made by qualified professionals who were not involved with the original action.

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 3667C, IAB 3/14/18, effective 2/14/18]

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.14(249A) Continuation of benefits. The managed care organization shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to October 16, 2015.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- a. The enrollee withdraws the appeal request;
- b. Ten days pass after the MCO mailed the notice providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten-day time frame, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or
- c. The time period or service limits of a previously authorized service have been met.

73.14(2) If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization or the state fair hearing officer

reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the managed care organization must pay for these services.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.15(249A) Grievances. The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.16(249A) Written record. All enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions. The managed care organization's written procedures for the review of managed care organization decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.
[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.18(249A) Records and reports.

73.18(1) Records system. The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, throughout the course of the contract. The records system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of decisions made by the managed care organization, based upon medical necessity.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the managed care organization including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) Content of individual treatment record. The managed care organization shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015. Beginning January 1, 2021, the managed care organization shall require use of an electronic visit verification system for personal care services.

73.18(3) Confidentiality of health care, mental health care, and substance abuse information. The managed care organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.
[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, that pertain to services performed and the determination of amounts paid under

the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.20(249A) Marketing. Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.21(249A) Enrollee education.

73.21(1) Use of services. The managed care organization shall provide written information to all enrollees on the use of services the managed care organization is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of managed care organization decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) Outreach to members with special needs. The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual impairments or who are deaf or hard of hearing.

73.21(3) Patient rights and responsibilities. The managed care organization shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—73.22(249A) Payment to the managed care organization.

73.22(1) Capitation rate. In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms defined in the managed care contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act, the health insurance providers fee. This capitation rate, inclusive of the amounts withheld and the health insurance providers fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the managed care organization meets metrics defined in the managed care contract.

73.22(2) Determination of rate. The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to October 16, 2015, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) Third-party liability. If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

73.22(4) Medical loss ratio. The managed care organization shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the managed care organization.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.23(249A) Claims payment by the managed care organization.

73.23(1) The managed care organizations shall pay or deny:

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

73.23(2) Limits on payment responsibility for services.

a. The managed care organization is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The managed care organization has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided at rule 441—73.7(249A).

73.23(3) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.24(249A) Quality assurance. The managed care organization shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

441—73.25(249A) Certifications and program integrity. The managed care organization shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code section 249A.4, 2015 Iowa Acts, Senate File 505, section 12, and 2019 Iowa Acts, House File 766, section 63.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed Emergency After Notice ARC 3667C (Notice ARC 3514C, IAB 12/20/17), IAB 3/14/18, effective 2/14/18]

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CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

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

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

441—77.3(249A) Hospitals.

77.3(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) *Referral to health home services provider.* As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

77.3(3) *Psychiatric bed tracking system.* As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

“*Adult beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

“*Child beds*” means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

“*Gender*” means female or male.

“*Geriatric beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

“*Hospital*,” for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

“*Psychiatric bed tracking system*” means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

- b. Hospitals are required to participate in the psychiatric bed tracking system.
- c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.
- d. Each update must include the number of child beds by gender, the number of adult beds by gender, and the number of geriatric beds by gender.
- e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 3789C, IAB 5/9/18, effective 7/1/18]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES —Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) Definitions.

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“*Rider*” means a notice issued by a surety that a change in the bond has occurred or will occur.

“*Uncollected overpayment*” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) Parties to surety bonds. The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) Surety company obligations. The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) Surety bond requirements. Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. *Amount of bond.* Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. *Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability

under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) Exemption from surety bond requirements for government-operated home health agencies. A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) Government-operated home health agency that loses its exemption. A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health’s standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists.

77.22(1) All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

77.22(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.22(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.
[ARC 2165C, IAB 9/30/15, effective 12/1/15; ARC 4165C, IAB 12/5/18, effective 1/9/19]

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), 77.25(4), and 77.25(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) Definitions.

“*Certified employment specialist*” or “*CES*” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“*Guardian*” means a guardian appointed in probate or juvenile court.

“*Individual placement and support*” or “*IPS*” means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition-2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

“*IPS 25-item supported employment fidelity scale*” means the fidelity scale published by the IPS Employment Center at Westat, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

“*IPS implementation*” means the process advocated by the IPS Employment Center at Westat, which consists of the following phases:

1. Formation of IPS team steering group and one-day meeting with the IPS trainer and team members.

2. Completion of the IPS Readiness Assessment developed by the IPS Employment Center at Westat and individual review with the IPS trainer.

3. Completion of a one-day IPS kick-off team training with the IPS trainer and team members.

4. Participation in individual team training and monthly consultations as follows:

- Two-and-a-half-day individual team training with the IPS trainer and team members.
- Virtual training by the IPS Employment Center at Westat for at least three people per team.
- Leadership training for two people per team at the IPS Employment Center at Westat.
- Virtual monthly technical assistance for two hours per month per team.

5. Participation in the International Learning Collaborative, including:

● Participation in the International Learning Collaborative annual conference by two people per state.

● Virtual monthly technical assistance calls with the IPS Employment Center at Westat mentor assigned to the team.

- Participation in the prescribed data tracking and management activities.

6. Completion of one baseline fidelity review per IPS team, with two IPS reviewers on site for two days per review.

7. Evaluation and development of next steps, with an on-site half-day meeting for the IPS trainer and the team.

“*IPS reviewer*” means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of “good” or better, has completed the IPS Employment Center at Westat’s training to become an IPS reviewer, and has shadowed one or more IPS fidelity reviews;

2. An existing IPS reviewer from a state which is a member of the IPS International Learning Collaborative;

3. An IPS reviewer contracted directly from the IPS Employment Center at Westat;

4. A CES with a bachelor’s degree who has completed the IPS Employment Center at Westat’s training to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

“*IPS team*” means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

“*IPS trainer*” means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of “good” or better, and has completed the IPS Employment Center at Westat’s training to become an IPS trainer;

2. An existing IPS trainer from a state which is a member of the IPS International Learning Collaborative;

3. An IPS trainer contracted directly from the IPS Employment Center at Westat;

4. A CES with a bachelor’s degree who has completed the IPS Employment Center at Westat’s training to become an IPS trainer.

“*Major incident*” means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the member;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Minor incident*” means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

“*Prospective IPS team*” means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a.

“*Provider-owned or controlled setting*” means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial

relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

“Provisionally approved IPS team” means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a, and (3) begun to deliver IPS services.

77.25(2) Organization and staff.

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

b. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) Restraint, restriction, and behavioral intervention. The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) Residential and nonresidential settings. Effective March 17, 2022, all home- and community-based services (HCBS), whether residential or nonresidential, shall be provided in integrated, community-based settings that support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Settings shall optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

a. Nursing facilities, institutions for mental diseases, intermediate care facilities for persons with an intellectual disability, and hospitals are not considered integrated, community-based settings.

b. Any HCBS setting that is located in a building that is also a publicly or privately operated facility, identified in paragraph 77.25(5) "a," that provides inpatient treatment or in a building on the grounds of, or immediately adjacent to, a public institution, identified in paragraph 77.25(5) "a," or any setting that has the effect of isolating members receiving Medicaid HCBS from the broader community will be presumed to be a setting that has the qualities of an institution unless the department conducts a site-specific review and determines otherwise.

c. Residential services may be provided in provider-owned or controlled settings. In provider-owned or controlled residential settings:

(1) The member selects the setting from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.

(2) The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and resources available for room and board.

(3) Members have choices regarding services and supports received and who provides them.

(4) Members are assured the rights of privacy, dignity, respect, and freedom from coercion and undue restraint.

(5) Services and supports shall optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

(6) Each member shall be afforded privacy in the member's sleeping and living unit. Living unit entrance doors and bedroom doors may be locked by the member, and only appropriate staff shall have keys. Staff access to keys must be identified in the member's person-centered plan.

(7) Members shall have a choice of roommates in that setting.

(8) Members shall have the freedom to furnish and decorate their sleeping or living areas as desired as permitted by any operative lease or other agreement.

(9) Members shall have the freedom and support to control their own schedules and activities and shall have access to food at any time.

(10) Members may have visitors of their choosing at any time.

(11) The setting shall be physically accessible to the member.

77.25(6) Case management. A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.25(7) Day habilitation.

a. The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) "a"(1), 77.25(7) "a"(4), or 77.25(7) "a"(7).

(3) An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

b. Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701—paragraph 78.27(8) "a," as offered through DirectCourse or Relias or other nationally recognized training curriculum.

(4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701—paragraph 78.27(8)“a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

77.25(8) Home-based habilitation. The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

77.25(9) Prevocational habilitation.

a. The following providers may provide prevocational services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

(4) An agency that is certified by the department to provide prevocational services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.25(10) Supported employment habilitation.

a. The following agencies may provide supported employment services:

(1) An agency that is certified by the department to provide supported employment services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(3) An agency that is accredited by the Council on Accreditation.

(4) An agency that is accredited by the Joint Commission.

(5) An agency that is accredited by the Council on Quality and Leadership.

(6) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

d. Providers qualified to offer IPS services shall meet the following requirements:

(1) Providers shall meet the provider qualifications listed in this subrule.

(2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.

(3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.

(4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.

(5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.25(1) and as outlined by the IPS Employment Center at Westat.

(6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a “fair” score on a baseline fidelity review completed by IPS reviewers.

(7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a within 12 months of enrolling.

(8) Upon completion of IPS implementation phase 4a, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.

(9) Upon completion of IPS implementation phase 7, IPS teams are qualified to deliver IPS services, subject to the following:

1. IPS teams must obtain a baseline fidelity review score of “fair” or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.

2. In the event an IPS team fails to achieve a fidelity score of “fair” or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than “fair” fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches “fair” fidelity, whichever date is earliest.

3. IPS teams who do not achieve a “fair” fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum “fair” fidelity score.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5809C, IAB 7/28/21, effective 9/1/21]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) Licensed marital and family therapists (LMFT). Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) Temporarily licensed marital and family therapists. Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

77.26(3) Licensed independent social workers (LISW). Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(4) Licensed master social workers (LMSW).

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

- (1) Holds a master’s or doctoral degree as approved by the board of social work; and
- (2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

- (1) Is duly licensed to practice in that state; and
- (2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(5) Licensed mental health counselors (LMC). Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible

to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(6) *Temporarily licensed mental health counselors.* Any person temporarily licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.26(7) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

77.26(8) *Licensed behavior analysts.* Any person licensed by the board of behavioral science as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.26(9) *Licensed assistant behavior analysts.* A person licensed by the board of behavioral science as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

- a. Holds current certification as an assistant behavior analyst by a certifying entity; and
- b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

This rule is intended to implement Iowa Code chapter 249A.
[ARC 9649B, IAB 8/10/11, effective 8/1/11; ARC 4165C, IAB 12/5/18, effective 1/9/19]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);
- b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

[ARC 1807C, IAB 1/7/15, effective 3/1/15]

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) Standards in 441—Chapter 24. Providers shall be accredited as case management providers pursuant to 441—Chapter 24 as a condition of providing case management services to persons with an intellectual disability, developmental disabilities or chronic mental illness.

77.29(2) Standards in 441—Chapter 186. Rescinded IAB 10/12/05, effective 10/1/05.

[ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.30(1) Homemaker providers. Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) Nursing care providers. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) Respite care providers.

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

- (5) Camps certified by the American Camping Association.
- (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
- (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
 - (1) At least 18 years of age.
 - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
 - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
 - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) Interim medical monitoring and treatment providers.

- a. The following providers may provide interim medical monitoring and treatment services:
 - (1) Home health agencies certified to participate in the Medicare program.
 - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
 - (1) Be at least 18 years of age.
 - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
 - (3) Not be a usual caregiver of the member.
 - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.
- c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) Personal emergency response system providers. Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) Home-delivered meals. The following providers may provide home-delivered meals:

- a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on

aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- a. The financial institution shall either:
 - (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
 - (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- a. The broker must be at least 18 years of age.
- b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- c. The broker shall not provide any other paid service to the member.
- d. The broker shall not work for an individual or entity that is providing services to the member.
- e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

- a. A business providing self-directed personal care services shall:
 - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
 - (2) Have current liability and workers' compensation coverage.
- b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c. All personnel providing self-directed personal care services shall:
 - (1) Be at least 16 years of age.
 - (2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.

2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.

3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the

member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule

77.33(22) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

77.33(22) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. Definitions.

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.

3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.33(23) Assisted living on-call service. Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3874C**, IAB 7/4/18, effective 8/8/18]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.34(1) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) Homemaker providers. Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) Nursing care providers. Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) Respite care providers.

a. The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.
- (3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
- (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) Home-delivered meals. The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

- c. Hospitals enrolled as Medicaid providers.
- d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- e. Restaurants licensed and inspected under Iowa Code chapter 137F.
- f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
- g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
 - (1) At least 18 years of age.
 - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
 - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
 - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult

abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or

non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15) "a"(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by

an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS intellectual disability waiver service providers.

77.37(1) Organizational standards (Outcome 1). Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. *Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"*Minor incident*" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. 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.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) Certification process. Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.37(11) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent

or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At

that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e."

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) Review of providers. Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13) "e" and 77.37(13) "f."

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) Supported community living providers.

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) Respite care providers.

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for persons with an intellectual disability, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with an intellectual disability licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) Supported employment providers.

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The

person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(17) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) Nursing providers. Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

- (1) Home health agencies certified to participate in the Medicare program.
- (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- (1) Be at least 18 years of age.
- (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
- (3) Not be a usual caregiver of the member.
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

- (1) Agencies licensed as group living foster care facilities under 441—Chapter 114.
- (2) Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.
- (3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.

- Plans are made for the future based on the review and evaluation.
4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.
 5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.
 - c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:
 - (1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.
 - (2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.
 - (3) The provider's written agreement to work cooperatively with the department.
 - d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:
 - (1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.
 - (2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.
 - (3) The service plan shall identify the following:
 1. Strengths and needs of the child.
 2. Goals to be achieved to meet the needs of the child.
 3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
 4. Specific service activities to be provided to achieve the objectives.
 5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
 6. Date of service initiation and date of individual service plan development.
 7. Service goals describing how the child will be reunited with the child's family and community.
 - (4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.
 - (5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.
 - (6) The individual service plan shall be revised when any of the following occur:
 1. Service goals or objectives have been achieved.
 2. Progress toward goals and objectives is not being made.
 3. Changes have occurred in the identified service needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.
 4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.
 - (7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.

- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."

- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."

- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).

- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) Transportation service providers. The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) Prevocational service providers.

a. Providers of prevocational services must be accredited by one of the following:

- (1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
- (2) The Council on Quality and Leadership accreditation in supports for people with disabilities.
 - b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
 - (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
 - (2) Member vacation, sick leave and holiday compensation.
 - (3) Procedures for payment schedules and pay scale.
 - (4) Procedures for provision of workers' compensation insurance.
 - (5) Procedures for the determination and review of commensurate wages.
 - c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
 - (1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
 - (2) A person providing direct support shall not be an immediate family member of the member.
 - (3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.
 - (4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(27) Day habilitation providers. Day habilitation services may be provided by agencies meeting the qualifications in subrule 77.25(7).

77.37(28) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5361C, IAB 12/30/20, effective 3/1/21]

441—77.38(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) Minimum composition. At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) Psychiatrists. A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 653—Chapter 9,
- b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and

c. Has experience treating serious and persistent mental illness.

77.38(3) Registered nurses. A nurse on the team shall:

a. Be licensed as a registered nurse under 655—Chapter 3, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(4) Mental health service providers. A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 645—Chapter 31, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master or independent social worker under 645—Chapter 280, and

(2) Has experience treating persons with serious and persistent mental illness.

77.38(5) Psychologists. A psychologist on the team shall:

a. Be licensed under 645—Chapter 240, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(6) Substance abuse treatment professionals. A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8) “i,” and

b. Have at least three years of experience treating substance abuse.

77.38(7) Peer specialists. A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) Community support specialists. A community support specialist on the team shall be a person who:

a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) Case managers. A case manager on the team shall be a person who:

a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

77.38(10) Advanced registered nurse practitioners. An advanced registered nurse practitioner on the team shall:

a. Be licensed under 655—Chapter 7,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.38(11) Physician assistants. A physician assistant on the team shall:

a. Be licensed under 645—Chapter 326,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management,

independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS brain injury waiver service providers.

77.39(1) Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) Intake, admission, service coordination, discharge, and referral.

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) Certification process. Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process

is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11) "f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) Departmental reviews. Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "c" and "d."

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) Case management service providers. Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) Supported community living providers.

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) Respite service providers. Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS intellectual disability waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) Supported employment providers.

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(16) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) Transportation service providers. This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) Family counseling and training providers. Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

f. Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

77.39(22) *Prevocational services providers.*

a. Providers of prevocational services must be accredited by one of the following:

(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

(6) Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

77.39(24) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member’s plan of care. The training or experience required must be determined by the member’s usual caregivers and a licensed medical professional on the member’s interdisciplinary team and must be documented in the member’s service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 1638C, IAB 10/1/14, effective 11/5/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—77.40(249A) *Lead inspection agencies.* The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) *HCBS physical disability waiver service providers.* Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers. The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS physical disability waiver service providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

- a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.
- b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide consumer-directed attendant care and who is:
 - (1) At least 18 years of age.
 - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) Home and vehicle modification providers. The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) Transportation service providers. The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.

3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.42(249A) Public health agencies. Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and
2. Meets the following additional requirements.

77.43(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- (1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
- (2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School

governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603, is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) Licensure. Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) Documentation. Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

[ARC 2930C, IAB 2/1/17, effective 4/1/17]

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) General provider standards. All providers of HCBS children's mental health waiver services shall meet the following standards:

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.

2. Consumers are a part of community life.

3. Consumers develop meaningful goals.

4. Consumers maintain physical and mental health.

5. Consumers are safe.

6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

- a. A community business that:
 - (1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and
 - (2) Submits verification of current liability and workers' compensation insurance.
- b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.
- c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.
- d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.
- e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

- (1) Behavioral health intervention providers qualified under 441—77.12(249A).
- (2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
 1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)“c” for the children’s mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children’s mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer’s interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer’s crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer’s parents or legal guardian, regarding the consumer’s individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer’s mental health or change the consumer’s crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children’s mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) In-home family therapy providers.

a. Qualified providers. The following agencies may provide in-home family therapy under the children’s mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children’s mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency’s mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)“c” for the children’s mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) Respite care providers.

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

- (1) The care must be approved by the parent, guardian or usual caregiver;
- (2) The care must be approved by the interdisciplinary team in the consumer's service plan;
- (3) The care must be consistent with the way the location is used by the general public; and
- (4) Respite care in these locations shall not exceed 72 continuous hours.

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 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) Qualifications. A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. Staffing. At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

b. Data management. A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

c. Collaboration with case managers. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. Provision of integrated health home services. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with an Iowa Medicaid managed care organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) Report on quality measures. As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) Selection. As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member’s health home, as reported by provider attestation.

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; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 5418C, IAB 2/10/21, effective 4/1/21]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider’s payment arrangements with such facilities or supervising providers.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.51(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

[ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—77.52(249A) Community-based neurobehavioral rehabilitation services.

77.52(1) Definitions.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Brain injury*” means a diagnosis in accordance with rule 441—83.81(249A).

“*Health care*” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“*Intermittent community-based neurobehavioral rehabilitation services*” means services provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Neurobehavioral rehabilitation*” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“*Standardized assessment*” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s needs.

77.52(2) Eligible providers. The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.52(3) Provider standards. All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members’ needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator’s absence.

(5) A minimum of 75 percent of the organization’s administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor’s degree in a human services-related field;

2. Have an associate’s degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a certified brain injury specialist (CBIS) certified through the Academy for the Certification of Brain Injury Specialists (ACBIS) or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.
2. Compensatory strategies to assist in managing ADLS (activities of daily living).
3. Quality of life issues.
4. Behavioral supports and identification of antecedent triggers.
5. Health and medication management.
6. Dietary and nutritional programming.
7. Assistance with identifying and utilizing assistive technology.
8. Substance abuse and addiction issues.
9. Self-management and self-interaction skills.
10. Flexibility in programming to meet members' individual needs.
11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.
12. Community accessibility and safety.
13. Household maintenance.
14. Service support to the member's family or support system related to the member's neurobehavioral care.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

- (1) Completion of the department-approved brain injury training modules.
- (2) Member rights.
- (3) Confidentiality and privacy.
- (4) Dependent adult and child abuse prevention and mandatory reporter training.
- (5) Individualized rehabilitation treatment plans.
- (6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.52(3) "a"(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBISs certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

f. The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

- (1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member's treatment team mutually develop an individualized service plan (ISP) that takes into account the member's individual strengths, barriers and interests. The service plan shall include goals which are based on the member's need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and the member's treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

(4) The member and the member's legal representative have the right to file grievances regarding the provider's implementation of the organizational standards, or its employee's or contractual person's action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with rules 481—63.21(135C), 481—63.27(135C), and 481—63.28(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;

2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;

3. Exclusionary time out;

4. Intensive staffing for control of behavior;

5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;

6. Reprimand;

7. Response cost; and

8. Use of psychotropic medications to control the occurrence of an unwanted behavior.

(6) Members receive individualized services.

(7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.

(8) Members receive assistance with accessing financial management services as needed.

(9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.

(10) The member's living environment is reasonably safe and located in the community.

(11) The member's desire for intimacy is respected and supported.

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—77.53(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider.

77.53(1) Reimbursement. A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.53(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—77.54(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program.

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—77.55(249A) Crisis response services.

77.55(1) Definitions. The terms used in this rule shall have the same meaning as set out in 441—Chapter 24, Division II.

77.55(2) Eligible providers. Agencies which are accredited under the mental health service provider standards established by the mental health and disability services commission, set forth in 441—Chapter 24, Division II, are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.55(3) Provider standards. All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24, Division II.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—77.56(249A) Subacute mental health services.

77.56(1) Definitions. The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.56(2) Subacute mental health services. Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.56(3) Eligible provider. Subacute mental health care facilities which are licensed by the department of inspections and appeals in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.56(4) Provider standards. All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—77.57(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

This rule is intended to implement Iowa Code section 249A.4.
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CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

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

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

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

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

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, 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. Reserved.

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

d. Acupuncture treatments.

e. Reserved.

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

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

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

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

d. Reserved.

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.

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

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

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

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

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

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

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

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

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

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

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.
- (4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma.

However, special consideration for exception will be given to cases involving children who may require a growth period.

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

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

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

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

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

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

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

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

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

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

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

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

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

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

78.1(11) Reserved.

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

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

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

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

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

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

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

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

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary

based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

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

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

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

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

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

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

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

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

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

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

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

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

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

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) “f”)

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

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

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

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

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

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

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

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

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

78.1(23) Reserved.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

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

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

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

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

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21]

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

78.2(1) Qualified prescriber. All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders shall be available for audit by the department.

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

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

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

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

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

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

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

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

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

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

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

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

(4) Reserved.

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

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

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

(8) Drugs prescribed for fertility purposes.

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

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

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

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

78.2(5) Nonprescription drugs.

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 81 mg, chewable
Aspirin tablets 81 mg, 325 mg, and 650 mg oral
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaiifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Levonorgestrel 1.5 mg
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Vitamins, single and multiple with prior authorization
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

78.2(6) Quantity prescribed.

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

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

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

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

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

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

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

78.3(8) Reserved.

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

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

a. Recipient selection and education.

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

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

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

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

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

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

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

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

The team should consist of:

A surgeon director.

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

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

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

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

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

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

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

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.
Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.
Pharmaceutical services.
Physical therapy.
Psychiatry.
Psycho-social.

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

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

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

c. *Experience and survival rates.*

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must

specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

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

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

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

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

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

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

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

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

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

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

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

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

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level

of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

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

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

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

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

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

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

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

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

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

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

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

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

78.3(17) Reserved.

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

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

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

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

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

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

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

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

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

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

c. Reserved.

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) Reserved.

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

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

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

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

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

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

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

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(1))

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

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) "a"(2))

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

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

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

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

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

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

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

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

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3) "c")

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

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

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

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

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

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

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

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

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

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

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

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

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) “c”)

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

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

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

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

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

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

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

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

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

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

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

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

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

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

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.

- d. Shoe padding when appliances are not practical.
- e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f. Rams horn (hypertrophic) nails.
- g. Onychomycosis (mycotic) nails.

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

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

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

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Gonioscopy.

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

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

(5) External photography.

(6) Fundus photography.

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

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

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

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

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

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

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. Reserved.

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

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

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

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

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

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

a. Materials payable by fee schedule are:

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

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

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

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

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

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

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

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

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

(Cross reference 78.28(4))

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

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

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

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

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

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

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

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

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

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

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

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

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

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

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

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

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

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

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

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

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

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

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

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

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

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

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

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

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

78.9(8) Medical social services. Rescinded IAB 3/29/17, effective 5/3/17.

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

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

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

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

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

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

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

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

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

- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

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

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

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

a. Definitions.

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

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

Private duty nursing or personal care services do not include:

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

6. Homework assistance.

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

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

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

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

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

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

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

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

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

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

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

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

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

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

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

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

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

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

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

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

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

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

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

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

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

EXCEPTIONS:

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

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

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

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

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

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

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

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

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

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

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

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

Automated medication dispenser.

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

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

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)“*a*” for prior authorization requirements.

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

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)“*c*” for prior authorization requirements.

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

Lymphedema pump.

Mobility device and accessories. See 78.10(5)“*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

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

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

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

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

Traction equipment.

Ventilator.

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

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

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

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

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

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

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

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;

3. Positioning accessories;
 4. Specialized skin protection seat and back cushions; and
 5. Anti-rollback devices.
- (3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:
1. Lap belt or safety belt;
 2. Battery charger, single mode;
 3. Complete set of tires/wheels and casters, any type;
 4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
 5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
 6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
 7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
 8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 10. Non-expandable controller or standard proportional joystick (integrated or remote); and
 11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).
- (4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
 2. Elevating legrest;
 3. Angle adjustable footplates;
 4. Adjustable height armrests; and
 5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).
- (5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.
- 78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.
- a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.
 - b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:
 - (1) Artificial eyes.
 - (2) Artificial limbs.
 - (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
 - (4) Hearing aids. See rule 441—78.14(249A).

- (5) Orthotic devices. See 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

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

- (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
 - 1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
 - 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

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

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

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

- Catheter (indwelling Foley).
- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
- Dialysis supplies.
- Disposable catheterization trays or sets (sterile).
- Disposable irrigation trays or sets (sterile).
- Disposable saline enemas (e.g., sodium phosphate type).
- Dressings.
- Elastic antiembolism support stocking.
- Enema.
- Hearing aid batteries.
- Incontinence products (for members three years of age and older).
- Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
- Ostomy appliances and supplies.
- Respirator supplies.
- Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

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

Catheter (indwelling Foley).

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

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Ostomy appliances and supplies.

Shoes, diabetic.

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

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

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

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

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

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

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

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

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

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

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

d. Rescinded IAB 12/30/20, effective 3/1/21.

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

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

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

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

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

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

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

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

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

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

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

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

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

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

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged

from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

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

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

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

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

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

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

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

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

78.12(1) Definitions.

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

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

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Family training services shall:

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

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

(2) Training provided must:

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

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

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

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

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

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

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

78.12(3) Excluded services.

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

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

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

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

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

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

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

(2) Diagnosis and treatment plan development are covered services.

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

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

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

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

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

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

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

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

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) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.

A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical,

functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

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

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

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. Reserved.

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. Reserved.

b. Education, which shall include as appropriate education about the following:

- (1) High-risk medical conditions.
 - (2) High-risk sexual behavior.
 - (3) Smoking cessation.
 - (4) Alcohol usage education.
 - (5) Drug usage education.
 - (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
- (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
- (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
- (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Certified employment specialist*” or “*CES*” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“Customized employment” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” or *“IPS”* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition-2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.
2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.
4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.
5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.
6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“*Integrated health home*” means the provision of services to enrolled members as described in subrule 78.53(1).

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“*Supported employment*” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“*Supported self-employment*” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has

been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

e. Plan for service. The department has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.
- b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
- c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- d. Service components that are the same or similar shall not be provided simultaneously.
- e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
- f. Reimbursement is not available for room and board.
- g. Services shall be billed in whole units.
- h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. *Scope.* Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Exclusions.*

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. *Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. *Exclusions.* Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member’s individual goals as identified in the member’s comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member’s interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member’s individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member’s ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,
- (12) Assistance with developing and maintaining natural relationships in the community,
- (13) Assistance with identifying and using natural supports,
- (14) Assistance with accessing financial literacy and benefits education,
- (15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member’s home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member’s residence. Family training may be provided in the member’s home.

e. Duration. Day habilitation services shall be furnished as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member’s comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment,

long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business

days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)“a”(1). This time limit can be extended as stated in paragraphs 78.27(9)“e”(1)“1” through “6.” If the criteria in paragraphs 78.27(9)“e”(1)“1” through “6” do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)“a”(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.
- b. *Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member’s personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider’s organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).

12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.

13. Transportation of the member during service hours.
 14. Career exploration services leading to increased hours or career advancement.
- (5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment.

In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member’s comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member’s residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member’s employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.

2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.

3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.

4. Rapid job search and systematic job development. CESs help members seek jobs directly, and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.

5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.

6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.

2. Outcome #2: First day of successful job placement.

3. Outcome #3: 45 days successful job retention.

4. Outcome #4: 90 days successful job retention.

e. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above

minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay.

When a member has been an inpatient in a medical institution for 120 consecutive days, the department

will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5809C, IAB 7/28/21, effective 9/1/21]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“*l.*”

d. Reserved.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“*f.*”

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“*c.*”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”

- j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“*c.*”
- k.* DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5)“*e.*”
- l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“*n.*”
- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“*g.*”
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“*h.*”
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“*i.*”
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“*j.*”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs, subject to the requirements of 78.10(2)“*d.*”

78.28(2) Notwithstanding the provisions of 78.28(1)“*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a.* Buprenorphine,
- b.* Buprenorphine and naloxone combination,
- c.* Methadone,
- d.* Naltrexone, and
- e.* Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
 - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“*b.*”
 - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“*d.*”
 - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“*e.*”
 - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“*f.*”
 - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“*g.*”
- b.* The following prosthetic services:
 - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*b.*”
 - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*d.*”
 - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*c.*”
 - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*e.*”
 - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“*k.*”
 - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“*l.*”
 - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“*m.*”
 - (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“*n.*”

- c.* The following orthodontic services:
- (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“*a.*”
 - (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“*b.*”
 - (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“*c.*”
- d.* The following restorative services:
- (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“*d*”(3).
 - (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“*d*”(4).
- e.* Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“*d.*”
- f.* Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“*g.*”

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

- a.* A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.
- b.* Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.
- c.* Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.
- d.* Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.
- e.* Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

- a.* Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7)“*d*”(1))
- b.* A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)“*d*”(2)):
- (1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.
 - (2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise

or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

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

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services

shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

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

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12)“*a,*” prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a.* Emergency service.
- b.* Outpatient surgery.
- c.* Laboratory, X-ray and other diagnostic services.
- d.* General or family medicine.
- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs "d" and "f" and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall

apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected

as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

- a. Components of the service include, but are not limited to:
 - (1) Observation and reporting of physical or emotional needs.
 - (2) Helping a client with bath, shampoo, or oral hygiene.
 - (3) Helping a client with toileting.
 - (4) Helping a client in and out of bed and with ambulation.
 - (5) Helping a client reestablish activities of daily living.
 - (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
 - (7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
 - (8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would

typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)“f” and the skilled activities listed in paragraph 78.34(7)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) Consumer choices option. The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or

goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.

4. Basic individual respite care.
 5. Specialized medical equipment.
 6. Supported community living.
 7. Supported employment.
 8. Transportation.
- (6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:
1. Consumer-directed attendant care (unskilled).
 2. Home and vehicle modification.
 3. Specialized medical equipment.
 4. Transportation.
- (7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.
- (8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.
- (9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.
- (10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).
- (11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.
- (12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.
- c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.
- d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:
- (1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
24. Residential services provided to three or more members living in the same residential setting.
 - (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."
 - f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.
 - (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
 5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.
 - (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.
 - (3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:
 1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or community-based case manager.
 - (4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.

(2) Verify employee qualifications.

(3) Specify additional employee qualifications.

(4) Determine employee duties.

(5) Determine employee wages and benefits.

(6) Schedule employees.

(7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
 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) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
 - (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
 - (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
 - (6) Verify for the member an employee's citizenship or alien status.
 - (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
 - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
 - (9) Establish and manage documents and files for the member and the member's employees.
 - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet (Form 470-4429) or use Form 470-4429. All other employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3552C**, IAB 1/3/18, effective 2/7/18; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5597C**, IAB 5/5/21, effective 7/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.

4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter

83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance

with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "f" and the skilled activities listed in paragraph 78.37(15) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per

day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) “f” and the skilled activities listed in paragraph 78.38(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
- (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
- (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
- (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) Vaccines administered to children. Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) Vaccines administered to adults. Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

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

[ARC 5175C, IAB 9/9/20, effective 6/1/21]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members

receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

- 1. An in-home medical communications transceiver.
- 2. A remote, portable activator.
- 3. A central monitoring station with backup systems staffed by trained attendants at all times.
- 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

- 1. A portable communications transceiver or transmitter to be worn or carried by the member.
- 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social

isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) “*f*” and the skilled activities listed in paragraph 78.43(13) “*g*.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “*b*,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical

care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5597C**, IAB 5/5/21, effective 7/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)“f” and the skilled activities listed in paragraph 78.46(1)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The necessary components of a system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit of service is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child’s needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child’s strengths and preferences;
- (2) Consider the child’s physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child’s medical, social, educational, and other service needs.

These actions may include activities such as ensuring the active participation of the child and working with the child or the child’s authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) Child's eligibility. Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) Delivery of services. Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Reserved.

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) Reserved.

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. Reserved.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) Covered services. Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:
 - (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
 - (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
 - (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.
- b. Care coordination, which means assisting members with:
 - (1) Medication adherence;
 - (2) Chronic disease management;
 - (3) Appointments, referral scheduling, and reminders; and
 - (4) Understanding health insurance coverage.
- c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:
 - (1) Supporting health management;
 - (2) Improving disease control; and
 - (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
 - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
 - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:

1. Having a body mass index (BMI) over 25 for an adult, or

2. Weighing over the 85th percentile for the pediatric population.

(7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

(1) A psychotic disorder;

(2) Schizophrenia;

(3) Schizoaffective disorder;

(4) Major depression;

(5) Bipolar disorder;

(6) Delusional disorder; or

(7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23). [ARC 2166C, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Brain injury” means a diagnosis in accordance with rule 441—83.81(249A).

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“Intermittent community-based neurobehavioral rehabilitation services” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Neurobehavioral rehabilitation” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“Standardized assessment” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member's managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

- (8) Health and wellness management including dietary and nutritional programming;
 - (9) Progressive physical strengthening, fitness and retraining;
 - (10) Assistance with obtaining and use of assistive technology;
 - (11) Sobriety support development;
 - (12) Assistance with the self-identification of antecedent triggers;
 - (13) Assistance with preparation for transition to less intensive services including accessing the community;
 - (14) Flexibility in programming to meet individual needs;
 - (15) Assistance with re-learning coping and compensatory strategies;
 - (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
 - (17) Support and assistance with obtaining legal consultation and services;
 - (18) Assistance with community accessibility and safety;
 - (19) Assistance with re-learning household maintenance;
 - (20) Assistance with recreational and leisure skill development;
 - (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
 - (22) Opportunities to learn about brain injury and individual needs following brain injury;
 - (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
 - (24) Assistance with pursuit of education and employment goals;
 - (25) Protective oversight in the residential setting and community;
 - (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
 - (27) Transitional support and training;
 - (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
 - (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.
- c.* Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:
- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
 - (2) Modifying or adapting the member's environment to improve overall functioning;
 - (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
 - (4) Behavioral supports;
 - (5) Assistance with obtaining and use of assistive technology;
 - (6) Assistance with the self-identification of antecedent triggers;
 - (7) Flexibility in programming to meet the member's individual needs;
 - (8) Assistance with re-learning coping and compensatory strategies;
 - (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
 - (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
 - (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
 - (12) Transitional support and training;
 - (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.
- d.* Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.
- e.* Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.
- (2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.
- f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).
 - g. Quality review. The IME medical services unit may perform the quality review to evaluate:
 - (1) The time elapsed from referral to rehabilitation treatment plan development;
 - (2) The continuity of treatment;
 - (3) The length of stay per member;
 - (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
 - (5) Gaps in service;
 - (6) The results achieved;
 - (7) Member and stakeholder satisfaction;
 - (8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a. Consistent with the diagnosis and treatment of the member's condition;
- b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c. The least costly type of service that can reasonably meet the medical needs of the member; and
- d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.56(5) Documentation standards. Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician.

Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
 - (9) Discipline of the person providing the service.
 - (10) Certification period.
 - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
 - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
- 78.57(7)** Nursing, personal care, and psychosocial services do not include:
- a. Services provided to members aged 21 and older.
 - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
 - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
 - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
 - e. Transportation services.
 - f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
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- [Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
- [Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
- [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
- [Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
- [Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
- [Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
- [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
- [Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14]
- [Filed ARC 1297C (Notice ARC 1185C, IAB 11/13/13), IAB 2/5/14, effective 4/1/14]
- [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
- [Filed ARC 1696C (Notice ARC 1620C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1850C (Notice ARC 1729C, IAB 11/12/14), IAB 2/4/15, effective 4/1/15]
- [Filed ARC 1976C (Notice ARC 1901C, IAB 3/4/15), IAB 4/29/15, effective 7/1/15]
- [Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
- [Filed ARC 2166C (Notice ARC 2096C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]

- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
- [Filed ARC 2340C (Notice ARC 2115C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
- [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3005C (Notice ARC 2897C, IAB 1/18/17), IAB 3/29/17, effective 5/3/17]
- [Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]
- [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]
- [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]
- [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]
- [Filed ARC 3552C (Notice ARC 3374C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
- [Filed ARC 3553C (Notice ARC 3419C, IAB 10/25/17), IAB 1/3/18, effective 2/7/18]
- [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18), IAB 5/9/18, effective 6/13/18]
- [Filed ARC 3874C (Notice ARC 3784C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]
- [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]¹³
- [Filed ARC 4575C (Notice ARC 4444C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]
- [Filed ARC 4792C (Notice ARC 4628C, IAB 8/28/19), IAB 12/4/19, effective 1/8/20]
- [Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]
- [Filed ARC 4899C (Notice ARC 4763C, IAB 11/20/19), IAB 2/12/20, effective 3/18/20]¹⁴
- [Filed ARC 5175C (Notice ARC 4964C, IAB 3/11/20), IAB 9/9/20, effective 6/1/21]
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- [Filed ARC 5362C (Notice ARC 5229C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]
- [Filed ARC 5364C (Notice ARC 5228C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]
- [Filed ARC 5418C (Notice ARC 5276C, IAB 11/18/20), IAB 2/10/21, effective 4/1/21]
- [Filed ARC 5487C (Notice ARC 5336C, IAB 12/16/20), IAB 3/10/21, effective 4/14/21]
- [Filed ARC 5597C (Notice ARC 5437C, IAB 2/10/21), IAB 5/5/21, effective 7/1/21]
- [Filed ARC 5808C (Notice ARC 5619C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]
- [Filed ARC 5809C (Notice ARC 5623C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]

¹ Two ARCs

² Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

⁴ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁵ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁶ Two ARCs

⁷ Two ARCs

⁸ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

⁹ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

¹⁰ Two or more ARCs

¹¹ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

¹² May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

- ¹³ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹⁴ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

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

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

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

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

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

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

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

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

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

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

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

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

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

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

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

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

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

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

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<ol style="list-style-type: none"> 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day. For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual placement and support.	Fee schedule	Fee schedule in effect 7/1/21.
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment: Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) Ambulatory surgical centers.

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

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

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

79.1(5) Reimbursement for hospitals.

a. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

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

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

“GME/DSH fund implementation year” means 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

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

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

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

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

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

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

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

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

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

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

e. Add-ons to the base amount.

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

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average

case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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

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

(2) Reserved.

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

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

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

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

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

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

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient

remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

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

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

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

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

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

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

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

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

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

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will

be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Reserved.

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

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

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

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

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

k. Inflation factors, rebasing, and recalibration.

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

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

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

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

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

client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

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

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

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

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

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

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

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

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

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected

to remain in the hospital for a period of no less than 60 additional days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

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

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

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.

- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

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

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical

education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

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

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

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

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

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

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

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

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

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

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

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

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. *Final settlement for state-owned teaching hospital.*

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

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

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

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

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

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

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

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- | | |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission. |
| N | The condition was not present or developing at the time of the order for inpatient admission. |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission. |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

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

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

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

79.1(7) Physicians.

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

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7) “a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).
- (16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) “c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a

qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “h,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies’ average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)"*a*" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

2. The average state AAC determined pursuant to paragraph 79.1(8)"*b*" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)"*a*"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)"*a*" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)"*a*" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(2) The average state AAC determined pursuant to paragraph 79.1(8)"*b*" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)"*a*"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)"*a*" above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(2) The average state AAC determined pursuant to paragraph 79.1(8)"*b*" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

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

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one

provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

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

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

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

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Serious impairment to bodily functions, or

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

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

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

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

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

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

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

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

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

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

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

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

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

that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

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

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

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

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

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

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

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

Any excess reimbursement shall be refunded by the hospice.

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

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

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

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

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

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

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

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

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

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

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

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPSS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPSS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPSS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPSS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular

OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Reserved.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or.xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3294C**, IAB 8/30/17, effective 10/4/17; **ARC 3295C**, IAB 8/30/17, effective 10/4/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3292C**, IAB 8/30/17, effective 10/4/17; **ARC 3293C**, IAB 8/30/17, effective 10/4/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 3551C**, IAB 1/3/18, effective 2/7/18; **ARC 3716C**, IAB 3/28/18, effective 5/2/18; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 4067C**, IAB 10/10/18, effective 11/14/18; **ARC 4065C**, IAB 10/10/18, effective 12/1/18; **ARC 4066C**, IAB 10/10/18, effective 12/1/18; **ARC 4068C**, IAB 10/10/18, effective 12/1/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 4974C**, IAB 3/11/20, effective 4/15/20; **ARC 5175C**, IAB 9/9/20, effective 6/1/21; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5809C**, IAB 7/28/21, effective 9/1/21]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“Termination from participation” means a permanent exclusion from participation in the medical assistance program.

“Withholding of payments” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) Imposition and extent of sanction. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) Notice to third parties. When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. Components.

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) “d.” The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) “c” or “d,” 441—paragraph 77.33(6) “d,” 441—paragraph 77.34(5) “d,” 441—paragraph 77.37(15) “d,” 441—paragraph 77.39(13) “e,” 441—paragraph 77.39(14) “d,” or 441—paragraph 77.46(5) “i,” or 441—subparagraph 78.9(10) “a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Other service documentation as applicable.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
 3. Other service documentation as applicable.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.

4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
 7. Other service documentation as applicable.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician, nurse practitioner, physician assistant, or clinical nurse specialist orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.

6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
8. Other service documentation as applicable.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Waiver of informed consent.
 3. Prior authorization documentation.
 4. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 4. Other service documentation as applicable.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
 1. Department-approved standardized neurobehavioral assessment tool.
 2. Community-based neurobehavioral treatment order.
 3. Treatment plan.
 4. Clinical records documenting diagnosis and treatment history.
 5. Progress or status notes.
 6. Service notes or narratives.
 7. Procedure, laboratory, or test orders and results.
 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 9. Medication administration records.
 10. Other service documentation as applicable.
- (43) Child care medical services:
 1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar

days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) Procedures.

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using Form 470-5595, Outpatient Prior Authorization Request, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial of prescription drugs will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d).

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving

medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) “a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) “c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that

was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

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441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)“a”;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,

2. A dentist,

3. A certified nurse midwife,

4. A nurse practitioner, or

5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the hawki program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at www.imeincentives.com. The applicant shall use the website to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration website. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the website. Providers shall access the website to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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- [Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]
- [Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
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- [Filed ARC 0710C (Notice ARC 0588C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0713C (Notice ARC 0584C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
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- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]

- [Filed Emergency ARC 0840C, IAB 7/24/13, effective 7/1/13]
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- [Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
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- [Filed ARC 1152C (Notice ARC 0910C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1154C (Notice ARC 0919C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1153C (Notice ARC 0917C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1481C (Notice ARC 1391C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
- [Filed Emergency ARC 1519C, IAB 7/9/14, effective 7/1/14]
- [Filed Emergency ARC 1521C, IAB 7/9/14, effective 7/1/14]
- [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
- [Filed ARC 1609C (Notice ARC 1518C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
- [Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
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- [Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
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- [Filed ARC 2026C (Notice ARC 1921C, IAB 3/18/15), IAB 6/10/15, effective 8/1/15]
- [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
- [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
- [Filed Emergency ARC 2846C, IAB 12/7/16, effective 11/15/16]
- [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
- [Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3161C, IAB 7/5/17, effective 7/1/17]
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- [Filed Emergency ARC 3160C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]
- [Filed ARC 3292C (Notice ARC 3164C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
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- [Filed ARC 3294C (Notice ARC 3165C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3295C (Notice ARC 3167C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]

- [Filed ARC 3296C (Notice ARC 3163C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
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 [Filed ARC 4066C (Notice ARC 3909C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]
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- ¹ Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Two ARCs
- ³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ⁴ Two or more ARCs
- ⁵ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁶ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁷ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁸ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁹ Two ARCs
- ¹⁰ July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).
- ¹² July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹³ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]

[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*Advance directive*” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Clock hour*” means 60 minutes.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 as amended to December 4, 2017, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.6(16) “f.” MDS is described in subrule 81.13(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Rate determination letter” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Skills performance record” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Special population nursing facility” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity.

“Surgical or other invasive procedure” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 3717C, IAB 3/28/18, effective 7/1/18; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—81.2 Reserved.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1) “*b*,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) Reserved.

81.3(3) *Preadmission review.* The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14) “*b*,” using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14) “*c*,” using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

c. The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3) “*a*” has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident 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 resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “*a*” and 249A.4.
[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.4(249A) Arrangements with residents.**81.4(1)** Reserved.

81.4(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5)“c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

441—81.5(249A) Discharge and transfer. (See paragraph 81.13(6)“c.”)

81.5(1) Notice. When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.5(2) Case activity report. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

81.6(3) Submission of reports. All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the

facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) "e."

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

81.6(4) Payment at new rate.

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) Accrual basis. Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) Census of Medicaid members. Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.6(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent,

child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing

facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11) “h”(4) to 81.6(11) “h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider’s qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses; or

2. Actual rent payments.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) “*a.*”

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) “*d.*” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.6(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the

facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.6(15) Payment to new owner. An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility’s fiscal year will end.

81.6(16) Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate. This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess

payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care

patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs "d" and "e," in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph "d" times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
<p>Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</p>	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results

Standard	Measurement Period	Value	Source
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from a report submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)"g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider

Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement

rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) Case-mix index calculation.

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average

case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) Medicare crossover claims for nursing facility services.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.6(21) Nursing facility quality assurance payments.

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$15 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment

pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4428C, IAB 5/8/19, effective 7/1/19; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4900C, IAB 2/12/20, effective 3/18/20]

441—81.7(249A) Continued review.

81.7(1) Level of care. The IME medical services unit shall review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

81.7(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3) "b."

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.8 Reserved.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.6(16) "g," facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Reserved.

81.10(4) Periods authorized for payment.

- a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.
 - b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.
 - c. Payment will be approved for the day of admission but not the day of discharge or death.
 - d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.
 - e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.
 - f. Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.
 - g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.
 - h. Ventilator patients.
 - (1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.
 - (2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16) "f"(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.
 - i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.
 - j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:
 - (1) The wrong surgical or other invasive procedure is performed on a resident; or
 - (2) A surgical or other invasive procedure is performed on the wrong body part; or
 - (3) A surgical or other invasive procedure is performed on the wrong resident.
- 81.10(5) Supplementation.** Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.
- Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.
- a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2) “d,” medical supplies except for those listed in 441—paragraph 78.10(4) “b,” oxygen except under circumstances specified in 441—paragraph 78.10(2) “a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2) “a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.
- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 0714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4900C, IAB 2/12/20, effective 3/18/20]

441—81.11(249A) Billing procedures.

81.11(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

81.13(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. to d. Reserved.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.13(3) Distinct part requirement. All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) Civil rights. The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The facility must respect the resident's right to personal privacy, including the right to privacy in the resident's oral (that is, spoken or sign language), written, and electronic communications.

(3) Except as provided in subparagraph (4) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(4) The resident's right to refuse release of personal and clinical records does not apply to the following:

1. The release of personal and clinical records to a health care institution to which the resident is transferred; or

2. A record release that is required by law.

f. Grievances. A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of survey results. A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work. The resident has the right to:

(1) Refuse to perform services for the facility.

(2) Perform services for the facility if the resident chooses, when:

1. The facility has documented the need or desire for work in the plan of care.

2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

3. Compensation for paid services is at or above prevailing rates.

4. The resident agrees to the work arrangement described in the plan of care.

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:

(1) Privacy of such communications consistent with this section; and

(2) Access to stationary, postage, and writing implements at the resident's own expense.

j. Access and visitation rights.

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.

2. Any representative of the state.

3. The resident's individual physician.

4. The state long-term care ombudsman.

5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.

6. The agency responsible for the protection and advocacy system for mentally ill individuals.

7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.

8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident's use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

(1) If accessible to the facility;

(2) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident; and

(3) To the extent that such use may comply with state and federal law.

81.13(6) Admission, transfer and discharge rights.

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall including the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)"a"(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)"a," and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) Resident behavior and facility practices.

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.
 4. Communication.
 5. Vision.
 6. Mood and behavior patterns.
 7. Psychosocial well-being.
 8. Physical functioning and structural problems.
 9. Continence.
 10. Disease diagnoses and health conditions.
 11. Dental and nutritional status.
 12. Skin condition.
 13. Activity pursuit.
 14. Medications.
 15. Special treatments and procedures.
 16. Discharge potential.
 17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
 18. Documentation of participation in assessment.
 19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
 2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
 3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.
- (7) Automated data processing requirement.
1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.
 - Admission assessment.
 - Annual assessment updates.
 - Significant change in status assessments.
 - Quarterly review assessments.
 - A subset of items upon a resident's transfer, reentry, discharge, and death.
 - Background (face sheet) information, if there is no admission assessment.
 2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Reserved.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision impairment or the deaf or hard of hearing or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. Unnecessary drugs.

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or

4. Without adequate indications for its use; or

5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

(1) It is free of significant medication error rates of 5 percent or greater.

(2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph "c," licensed nurses.

2. Other nursing personnel.

(2) Except when waived under paragraph "c," the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

(1) Except when waived under paragraph "c," the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph "c," the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph "b," or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph "a," if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph "c" is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

- (1) Provide the required services; or
- (2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) May be provided only by a specialized licensed or certified practitioner;

- (5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

- (6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. "Specialized services for intellectual disability" means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;

- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) Must be supervised by a qualified intellectual disability professional; and

- (5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

- (1) Routine dental services to the extent covered under the state plan.
- (2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. Procedures. A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. Service consultation. The facility shall employ or obtain the services of a licensed pharmacist who:

- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. Drug regimen review.

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. Storage of drugs and biologicals.

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. Consultant pharmacists. When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. Infection control program. The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. Life safety from fire. Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. Emergency power.

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

(2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.

(3) Equip corridors with firmly secured handrails on each side.

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

e. Required training of nurse aides.

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

- (2) The facility shall:
 1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.
 2. Promptly notify the attending physician of the findings.
 3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
 4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.
 - l. *Clinical records.*
 - (1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.
 - (2) Clinical records shall be retained for:
 1. The period of time required by state law.
 2. Five years from the date of discharge when there is no requirement in state law.
 3. For a minor, three years after a resident reaches legal age under state law.
 - (3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.
 - (4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:
 1. Transfer to another health care institution.
 2. Law.
 3. Third-party payment contract.
 4. The resident.
 - (5) The clinical record shall contain:
 1. Sufficient information to identify the resident.
 2. A record of the resident's assessments.
 3. The plan of care and services provided.
 4. The results of any preadmission screening conducted by the state.
 5. Progress notes.
 - m. *Disaster and emergency preparedness.*
 - (1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
 - (2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.
 - n. *Transfer agreement.*
 - (1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
 1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
 2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
 - (2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
 - o. *Quality assessment and assurance.*
 - (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

- (2) The quality assessment and assurance committee:
 1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
 2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
- (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
- (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
 - p. Disclosure of ownership.*
 - (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
 - (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
 1. Persons with an ownership or control interest.
 2. The officers, directors, agents, or managing employees.
 3. The corporation, association, or other company responsible for the management of the facility.
 4. The facility's administrator or director of nursing.
 - (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) *Audit of proper billing and handling of patient funds.*

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.15 Reserved.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections and appeals if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours’ duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.16(2) State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “e” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2)“f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2)“b”(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2)“b”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved, such program shall, at a minimum:

(1) Consist of no less than 75 clock hours of training, and

(2) Include at least the subjects specified in 81.16(3) "b," and

(3) Include at least 30 hours of didactic theory instruction, which may be provided in a classroom setting or through online course curricula, and

(4) Include at least 15 hours of laboratory experience provided in a face-to-face environment that complements the didactic theory curricula, and

(5) Include 30 hours of supervised clinical training in a face-to-face environment and supervised by a department of inspections and appeals-approved instructor in a manner not inconsistent with the licensing requirements of the Iowa board of nursing, and

(6) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the department of inspections and appeals-approved instructor, and

(7) Meet the following requirements for department of inspections and appeals-approved instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed by registered nurses under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of department of inspections and appeals-approved instructors to students shall not exceed one registered nurse, or licensed practical nurse functioning as an assistant to a registered nurse, who is in the proximate area in the clinical setting, for every ten students in the clinical setting, and

(8) Contain information regarding competency evaluation through written or oral examination and skills demonstration.

b. The curriculum of the nurse aide training program shall include:

- (1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:
 1. Communication and interpersonal skills.
 2. Infection control.
 3. Safety and emergency procedures including the Heimlich maneuver.
 4. Promoting residents' independence.
 5. Respecting residents' rights.
- (2) Basic nursing skills:
 1. Taking and recording vital signs.
 2. Measuring and recording height and weight.
 3. Caring for the residents' environment.
 4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.
 5. Caring for residents when death is imminent.
- (3) Personal care skills, including, but not limited to:
 1. Bathing.
 2. Grooming, including mouth care.
 3. Dressing.
 4. Toileting.
 5. Assisting with eating and hydration.
 6. Proper feeding techniques.
 7. Skin care.
 8. Transfers, positioning, and turning.
- (4) Mental health and social service needs:
 1. Modifying aide's behavior in response to residents' behavior.
 2. Awareness of developmental tasks associated with the aging process.
 3. How to respond to resident behavior.
 4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
 5. Using the resident's family as a source of emotional support.
- (5) Care of cognitively impaired residents:
 1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
 2. Communicating with cognitively impaired residents.
 3. Understanding the behavior of cognitively impaired residents.
 4. Appropriate responses to the behavior of cognitively impaired residents.
 5. Methods of reducing the effects of cognitive impairments.
- (6) Basic restorative services:
 1. Training the resident in self-care according to the resident's ability.
 2. Use of assistive devices in transferring, ambulation, eating and dressing.
 3. Maintenance of range of motion.
 4. Proper turning and positioning in bed and chair.
 5. Bowel and bladder training.
 6. Care and use of prosthetic and orthotic devices.
- (7) Residents' rights:
 1. Providing privacy and maintenance of confidentiality.
 2. Promoting the residents' rights to make personal choices to accommodate their needs.
 3. Giving assistance in resolving grievances and disputes.
 4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
 5. Maintaining care and security of residents' personal possessions.

6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.

7. Avoiding the need for restraints in accordance with current professional standards.

c. Prohibition of charges.

(1) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may not be charged for any portion of the program including any fees for textbooks, course materials, or nurse aide competency evaluations.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

2. Divide the total arrived at in paragraph "1" above by 12 to prorate the costs over a one-year period and establish a monthly rate.

3. The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:

(1) Notify the department of inspections and appeals:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.

2. When a facility or other training entity will no longer be offering nurse aide training courses.

3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

(1) Written or oral examinations. The competency evaluation shall:

1. Allow an aide to choose between a written and oral examination.

2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3718C, IAB 3/28/18, effective 5/2/18]

441—81.17 Reserved.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) Use of independent assessors. If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

This rule is intended to implement Iowa Code section 249A.4.

441—81.19 Reserved.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) Out-of-state providers. Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

81.20(3) Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule

441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) *Beginning date of payment.* When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“*CMS*” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“*Deficiency*” means a nursing facility's failure to meet a participation requirement.

“*Department*” means the Iowa department of human services.

“*Immediate jeopardy*” means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) *Purpose of remedies.* The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) *Basis for imposition and duration of remedies.* The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) *Number of remedies.* The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) *Plan of correction requirement.*

a. Except as specified in paragraph “b,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) *Disagreement regarding remedies.* If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) *Notification requirements.*

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) Informal dispute resolution.

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

81.33(3) Other factors which may be considered in choosing a remedy within a remedy category. Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) Categories of remedies. Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) Application of remedies. After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) “a,” 81.35(4) “a,” and 81.35(5) “a,” for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) “b,” 81.35(4) “b,” and 81.35(5) “b,” as applicable.

81.35(3) Category 1.

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) Category 2.

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) Category 3.

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) Plan of correction.

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) Appeal of a determination of noncompliance.

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) Terminate agreement or appoint temporary manager. If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) Other remedies. The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

- a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;
- b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and
- c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

- a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).
- b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) Qualifications. The temporary manager must:

- a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.
- b. Not have been found guilty of misconduct by any licensing board or professional society in any state.
- c. Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.
- d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) Payment of salary. The temporary manager's salary:

- a. Is paid directly by the facility while the temporary manager is assigned to that facility.
- b. Shall be at least equivalent to the sum of the following:
 - (1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.
 - (2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.
 - (3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.
- c. May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) Failure to relinquish authority to temporary management.

- a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).
- b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) Optional denial of payment. Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) Required denial of payment. Payment for all new admissions shall be denied when:

- a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or
- b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) Resumption of payments. Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

- a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.
- b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) Resumption of payments. No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume

prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) Restriction. No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) CMS option to deny all payment. If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) Resumption of payment. When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) State monitor. A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) Use of state monitor. A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) Discontinuance of state monitor. State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

a. The facility has a pattern of deficiencies that indicate noncompliance; and

b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) Closure during an emergency. In an emergency, the department and the department of inspections and appeals have the authority to:

a. Transfer Medicaid and Medicare residents to another facility; or

b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) Required transfer in immediate jeopardy situations. When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) All other situations. Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) When facility requests a hearing.

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) When facility does not request a hearing. If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a.* Achieves substantial compliance; or
- b.* Is terminated.

81.47(3) When facility waives a hearing. If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a.* Achieves substantial compliance; or
- b.* Is terminated.

81.47(4) Accrual and computation of penalties. Accrual and computation of penalties for a facility that:

- a.* Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);
- b.* Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) Collection. The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.

8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) Reduction of penalty amount.

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) Amount of penalty. The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) "b."

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) Basis for penalty amount. The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) Decreased penalty amounts. Except as specified in 81.50(4) "b," if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) Increased penalty amounts.

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) Review of the penalty. When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

a. Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) Factors affecting the amount of penalty. In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

a. The facility's history of noncompliance, including repeated deficiencies.

b. The facility's financial condition.

c. The factors specified in rule 441—81.33(249A).

d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) Authority to settle penalties. The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.
[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) When penalty begins to accrue. The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) Duration of penalty. The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

- a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;
- b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or
- c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) Penalty due. The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) Notice after facility achieves compliance. When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

- a. The amount of penalty per day;
- b. The number of days involved;
- c. The total amount due;
- d. The due date of the penalty; and
- e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) Notice to terminated facility. In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

- a. Final administrative decision is made;
- b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
- c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) Accrual of penalties when there is no immediate jeopardy.

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) Accrual of penalties when there is immediate jeopardy.

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) Documenting substantial compliance.

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) When payments are due.

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

- (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
- (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

f. In the cases specified in paragraph "d," the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) Deduction of penalty from amount owed. The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) Interest. Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[ARC 9402B, IAB 3/9/11, effective 4/1/11; ARC 3717C, IAB 3/28/18, effective 7/1/18]

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) Criteria.

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

(1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;

(2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and

(3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“*a*” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“*a*” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1)“*a*” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

(1) CMS finds the facility is in substantial compliance with the participation requirements; and

(2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

(1) CMS finds that a facility has not achieved substantial compliance; and

(2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

(1) Impose any of the alternative remedies specified in rule 441—81.34(249A);

(2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and

(3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.

a. CMS’s decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility’s participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals’ decision to terminate a facility’s participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility’s participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

- a. A facility is not in substantial compliance; and
- b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) *Facility in compliance.* If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) *Effect of termination.* Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) *Basis of termination.*

a. A facility's provider agreement may be terminated if a facility:

- (1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

- (2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

- (1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

- (2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1) "a."

81.57(3) Notice of termination. Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

These rules are intended to implement Iowa Code section 249A.4.

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- ¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- ² Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- ³ Effective date of 81.13(7) "c"(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- ⁴ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- 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**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]

[Prior to 2/11/87, Human Services[498]]

441—82.1(249A) Definition.

“Department” means the Iowa department of human services.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermediate care facility for persons with medical complexity” means an intermediate care facility for persons with an intellectual disability which provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

82.2(1) Governing body and management.

a. Governing body. The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.
- (3) Appoint the administrator of the facility.

b. Compliance with federal, state, and local laws. The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. Client records.

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

(2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client's record.

d. Services provided under agreements with outside sources.

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs "a" to "g," "j," and "k."

e. Disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) Client protections.

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) Facility staffing.

a. Qualified intellectual disability professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified intellectual disability professionals who must meet the requirements set forth in 82.2(3)"a."

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly intellectually disabled clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately intellectually disabled clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild intellectual disability, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) *Active treatment services.*

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client's case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.

4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

5. The inappropriate client behaviors, if applicable.

6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.

2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.

2. Is regressing or losing skills already gained.

3. Is failing to progress toward identified objectives after reasonable efforts have been made.

4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who

have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4) "f"(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) Client behavior and facility practices.

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.
4. Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients shall participate in the formulation of these policies and procedures.

(3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

b. Management of inappropriate client behavior.

(1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5) "a." These procedures shall:

1. Specify all facility-approved interventions to manage inappropriate client behavior.
2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

(2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4) "c"(4) and (5).

(5) Standing or as-needed programs to control inappropriate behavior are not permitted.

c. Time-out rooms.

(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

1. The placement is a part of an approved systematic time-out program as required by 82.2(5) "b."

2. The client is under the direct constant visual supervision of designated staff.
3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

- (2) Placement of a client in a time-out room shall not exceed one hour.

- (3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

- (4) A record of time-out activities shall be kept.

d. Physical restraints.

- (1) The facility may employ physical restraint only:

1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.

3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

- (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.

- (3) The facility shall not issue orders for restraint on a standing or as-needed basis.

- (4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

- (5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

- (6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

- (7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

- (1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

- (2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

- (3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

- (4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) Health care services.

a. Physician services.

- (1) The facility shall ensure the availability of physician services 24 hours a day.

- (2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

- (3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.

2. Be by a licensed nurse.

3. Be on a quarterly or more frequent basis depending on client need.

4. Be recorded in the client's record.

5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.

2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.

3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. Pharmacy services. The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. Drug regimen review.

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. Drug administration. The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. Drug storage and record keeping.

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. Drug labeling.

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. Laboratory services.

(1) For purposes of this subrule, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) Physical environment.

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, hard of hearing, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

- (1) Bedrooms shall:
 1. Be rooms that have at least one outside wall.
 2. Be equipped with or located near toilet and bathing facilities.
 3. Accommodate no more than four clients unless granted a variance under 82.2(7)“b”(3).
 4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.
 5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.
- (2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.
- (3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.
- (4) The facility shall provide each client with:
 1. A separate bed of proper size and height for the convenience of the client.
 2. A clean, comfortable mattress.
 3. Bedding appropriate to the weather and climate.
 4. Functional furniture appropriate to the client’s needs, and individual closet space in the client’s bedroom with clothes racks and shelves accessible to the client.
- c. Storage space in bedroom.* The facility shall provide:
 - (1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.
 - (2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.
- d. Client bathrooms.* The facility shall:
 - (1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.
 - (2) Provide for individual privacy in toilets, bathtubs, and showers.
 - (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.
- e. Heating and ventilation.*
 - (1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.
 - (2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.
- f. Floors.* The facility shall have:
 - (1) Floors that have a resilient, nonabrasive, and slip-resistant surface.
 - (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.
 - (3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.
- g. Space and equipment.* The facility shall:
 - (1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations

if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. Emergency plan and procedures.

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. Evacuation drills.

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. Meal services.

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8) "b"(1)"1."

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. Menus.

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. Dining areas and service. The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) Procedures for establishing health care facilities as Title XIX facilities. All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual."

- a. The facility shall obtain the applicable license from the department of inspections and appeals.
- b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.
- c. The department shall transmit an application form and copies of standards to the facility.
- d. The facility shall complete its portion of the application form and submit it to the department.
- e. The department shall review the application form and forward it to the department of inspections and appeals.
- f. The department of inspections and appeals shall schedule and complete a survey of the facility.
- g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
- h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.
- i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
- j. When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.
- k. The department shall review the certification data and:
 - (1) Transmit the provider agreement as recommended, or
 - (2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

82.3(2) Title XIX provider agreements. The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for persons with an intellectual disability before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

- a. Terms of the agreement for facilities without deficiencies are as follows:
 - (1) The provider agreement shall be issued for a period not to exceed 12 months.
 - (2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.
- b. Terms of the agreement for facilities with deficiencies are as follows:

(1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.

(2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

(3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.

c. The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for persons with an intellectual disability in compliance with rules and regulations of the program.

d. The department may at its option extend an agreement with a facility for two months under either of the following conditions:

(1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

(2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.

f. When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) Appeals of decertification. A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.4 Reserved.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) Failure to maintain records. Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) *Submission of reports.* The facility's cost report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than September 30 each year except as described in subrule 82.5(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.5(3) "c."

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.5(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.5(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.5(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.5(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.5(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility,

consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.5(3) "c."

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.5(11) "e"(4) to 82.5(11) "e"(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first

entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.5(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) Assessed fee. The fee assessed pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.5(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.5(14) Payment to new facility. A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted

to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates.

The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14)“*d*,” shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year’s actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) *Payment to new owner.* An existing facility with a new owner shall continue with the previous owner’s per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) *Payment to existing facilities.* The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14)“*d*.”

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.
- (17) Data processing and bank charges.
- (18) Advertising.
- (19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 0995C, IAB 9/4/13, effective 11/1/13; ARC 2886C, IAB 1/4/17, effective 2/8/17]

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.7(249A) Initial approval for ICF/ID care.

82.7(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.7(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department shall:

(1) Approve ICF/ID placement;

- (2) Offer a home- or community-based alternative; or
- (3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.7(3) *Approval of level of care.* Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit.

82.7(4) *Appeal rights.* Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—16.3(17A).

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4973C**, IAB 3/11/20, effective 4/15/20]

441—82.8(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the client's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—82.9(249A) Arrangements with residents.

82.9(1) *Resident care agreement.* The ICF/ID Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.9(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.9(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.11(249A) Continued stay review. Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

441—82.12(249A) Quality of care review. Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

441—82.13(249A) Records.

82.13(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) Retention. Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Payment procedures.

82.14(1) Method of payment. Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) and 82.14(3) Reserved.

82.14(4) Periods authorized for payment.

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment

or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.15(249A) Billing procedures.

82.15(1) Claims. Claims for service for clients not enrolled with a managed care organization must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through IME's electronic clearinghouse.

a. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

b. Adjustments to claims may be made electronically as provided for by the Iowa Medicaid enterprise.

82.15(2) Reserved.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.16(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.17(249A) Audits.

82.17(1) Audits of financial and statistical report. Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on

the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.17(2) Auditing of proper billing and handling of patient funds.

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph "d" the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has

appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.

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◊ Two or more ARCs

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

[Prior to 7/1/83, Social Services [770] Ch 113]

[Prior to 2/11/87, Human Services[498]]

441—113.1(237) Applicability. This chapter specifically relates to the licensing and regulation of foster family homes. Refer to 441—Chapter 112 for general licensing rules and regulations which apply to all foster care facilities, including foster family homes.

This rule is intended to implement Iowa Code chapter 237.

441—113.2(237) Definitions.

“Age- or developmentally appropriate activities” means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

“Corporal punishment” means the intentional physical punishment of a foster child.

“Department” means the Iowa department of human services and includes the local offices of the department.

“Foster family home” means a home in which an individual person or persons or a married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

“Health care provider” means a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner who completes a health report.

“Public water supply system (PWS)” means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

“Reasonable and prudent parent standard” means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encourage the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, “caregiver” means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which a child in foster care has been placed.

“Reasonable force” means that force, and no more, which a reasonable person in like circumstances would judge to be necessary to prevent an injury or loss.

“Recruitment and retention contractor” means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

“Service area manager” means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

“Social work administrator” means the department employee responsible for supervising the social work staff within a department service area and for implementing service policies and procedures of the department.

This rule is intended to implement Iowa Code chapter 237.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 2069C, IAB 8/5/15, effective 10/1/15; ARC 2743C, IAB 10/12/16, effective 12/1/16; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.3(237) Licensing procedure.

113.3(1) Application. Applications for an initial license to operate a foster family home shall be submitted and processed as directed in rule 441—112.3(237). In addition to the application form, the applicant shall submit the following forms during the licensing process:

a. Form 595-1396, DHS Criminal History Record Check, for each person living in the home who is 14 years of age or older, as required by rule 441—113.13(237).

b. Form 470-0720, Physician's Report for Foster and Adoptive Parents, to satisfy the requirements of rule 441—113.11(237).

c. Form 470-0693, Foster Care Private Water Supply Survey, if applicable.

d. Form 470-4657, Floor Plan. The applicant or the recruitment and retention provider shall complete a drawing of the floor plan of the family's home.

e. If licensed to drive, a copy of the driver's license and motor vehicle insurance.

113.3(2) Orientation. Applicants shall attend an orientation provided by the recruitment and retention contractor as described in rule 441—117.2(237).

113.3(3) Record checks. Before beginning preservice training, applicants shall pass at least the local record check procedures as specified in rule 441—113.13(237).

113.3(4) Home study. The worker for the recruitment and retention contractor shall complete a family home study.

a. *Process.* Information for the home study is gathered primarily through the required preservice training as described in rule 441—117.1(237). Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C.A. Section 671(a)(26)(B) provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

(1) The worker shall hold at least two face-to-face interviews with the applicant with one of the interviews taking place in the applicant's home.

(2) The worker shall hold at least one face-to-face interview with each member of the household in the applicant's home to observe family functioning and to assess the family's capacity to meet the needs of a child in foster care. The worker will determine whether to interview or just observe each household member based on the household member's age and development.

(3) A physical inspection of the home is required. The worker shall use the Foster Family Survey Report to complete the physical inspection of the home to verify compliance with the licensing and regulation standards in this chapter.

(4) Reference checks shall be conducted as described at rule 441—113.14(237).

b. *Family assessment topics.* The assessment of the prospective foster family shall evaluate the family's ability to parent a special needs child. The assessment shall include the following:

(1) The applicant's motivation for foster care and whether the family has biological, adopted, or foster children.

(2) The attitude of the family and the extended family toward accepting a foster child.

(3) The applicant's emotional stability; marital relationship and history, including verification of marriages and divorces; family relationships; and compatibility.

(4) The applicant's ability to cope with problems, stress, frustrations, crisis, separation, and loss.

(5) Medical, mental, and emotional conditions that may affect the applicant's ability to parent a child; treatment history; current status of treatment; and the evaluation of the treatment. Applicants and all household members must disclose any past or current mental health or substance abuse issues, or both. The department may require further documentation or evaluation, or both, to determine the suitability of the home.

(6) All children who are household members must be up to date on immunizations jointly recommended by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the American Academy of Family Physicians, unless the immunization is contrary to the child's health as documented by a licensed health care professional.

(7) An evaluation of the applicant's willingness to accept a child who has medical problems (such as HIV), an intellectual disability, or emotional or behavioral problems. The applicant shall complete the

department form to indicate choices about caring for children who have or are at risk for HIV infection and other medical problems.

(8) The applicant's ability to provide for a child's physical, medical, and emotional needs and respect the child's ethnic and religious identity.

(9) The safety of foster children in relation to any animals that live on the applicant's property.

(10) The adjustment of any children in the home, including their attitudes toward foster care and adoption, relationships with others, and school performance.

(11) An assessment of the applicant's disciplinary techniques and practices.

(12) The applicant's financial information and ability to provide for a child.

(13) The applicant's attitude toward the foster child's birth parents and siblings.

(14) The applicant's commitment to and capacity to maintain a foster child's significant relationships and work with the child's parents when the permanency goal is reunification.

(15) Any history of substance use or substance abuse by family members or members of the household, including treatment history and current status of treatment.

(16) Any history of abuse by family members or members of the household, including treatment history, current status of treatment, and how this issue would affect the applicant's ability to be a foster parent.

(17) Any criminal convictions of family members or adults in the household and the evaluation of the criminal record.

c. Written report. The recruitment and retention contractor shall prepare a written report of the family assessment using Form 470-5436, Resource Parent Home Study. The Resource Parent Home Study shall include a recommendation for the number, age, sex, characteristics, and special needs of a child or children the family can best parent and any other pertinent information in making the licensing recommendation. The home study shall be maintained in the foster family record.

113.3(5) Decision. The department worker shall use the home study to approve or deny a prospective family as an appropriate placement for a child or children. The department worker shall notify the family of the licensing decision using Form 470-0709, Notice of Action: Foster Family Home.

a. Upon approval, the department shall issue the applicant a foster family home license as described at rule 441—112.4(237). The license shall indicate the licensed capacity for the number of foster children approved for placement in the foster family home under subrule 113.4(1).

b. If the department worker does not approve the home study, the notice shall state the reasons for that decision, as listed in rule 441—112.5(237). A license denial may be appealed as described at rule 441—112.8(237).

This rule is intended to implement Iowa Code section 237.5.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.4(237) Provisions pertaining to the license. On a case-by-case basis, the service area manager or area social work administrator may waive any standard in this chapter unless:

1. The requirement is set in state or federal law; or
2. The waiver could have a negative impact on the safety and well-being of a child placed in the foster family home.

113.4(1) Number of children. A foster family home may care for up to five children unless a variance is approved as described in this rule. The license capacity shall be based on the number of the foster family's biological and adoptive children and any relative placements. The license shall be issued for at least one child. A child who has reached the age of 18 and remains eligible for foster family care shall be included in the license capacity. Any variance to this rule must:

a. Be approved by the service area manager or designee.

b. Be documented in the licensing record with reasons given for granting the variance.

c. Meet one of the following criteria:

(1) The foster parents have three or more children in the home and have shown the ability to parent a large number of children. A licensing variance may be approved at initial or renewal licensure to allow the placement of up to three foster children as set forth in the chart below:

No. of Children in the Home (birth/relative/adoptive placements)	Maximum License Capacity:	
	Without variance	With variance
0 children	5	Not applicable
1 child	4	Not applicable
2 children	3	Not applicable
3 children	2	3
4 children	1	3
5 or more children	Not applicable	3

(2) A variance beyond the maximum capacity of the foster home license is needed for the placement of a specific child in foster family care. A child-specific variance shall end when that child leaves the placement or any other change brings the family into licensed capacity. Unless a variance is needed for the placement of a sibling(s) of a foster child already in the home, or to keep siblings together, the maximum number of children in the home shall not exceed eight. On a case-by-case basis, if it is determined the foster parents have shown the parenting skills and have the social support system to meet the children's needs for parenting more than eight children, the social work administrator shall approve the foster parents to parent more than eight children. A foster family may have both a licensing and a child-specific variance concurrently.

d. All other licensing requirements including, but not limited to, parenting ability and available bedroom space must be met before a foster home can be approved for a variance.

113.4(2) *Employees of the department as foster parents.* Employees of the department may be licensed as foster family home parents unless they are engaged in the administration or provision of foster care services. Employees engaged in the administration or provision of foster care services include:

a. Child care staff, social workers, youth service workers or their supervisors involved in programs for children in state institutions.

b. Foster care service workers, foster care licensing staff, and their supervisors employed in county or central offices of the department.

c. Other staff engaged in foster care placements, such as child protective staff or adoption workers.

d. Department staff responsible for the development of policies and procedures relating to foster care licensing and placement.

113.4(3) *Limits on foster family home licensure.* A licensed foster family home shall not be permitted to be a licensed comprehensive residential facility, community residential facility, or licensed child care center.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.5(237) Physical standards.

113.5(1) *General standards.* The foster home shall be safe, clean, well ventilated, properly lighted, properly heated, and free from vermin and rodents to ensure the well-being of the foster children residing in the home.

113.5(2) *Grounds.*

a. There shall be safe outdoor space provided according to the age and developmental needs of the foster child for active play. The area available shall be documented in the case record.

b. The foster child shall be adequately supervised and protected against hazards including, but not limited to, traffic, bodies of water, railroads, waste material, and contaminated water. The foster parent shall provide environmental protections such as door alarms, baby monitors, fences, and foliage barriers.

c. The applicant's home must meet the following standards concerning swimming pools, hot tubs and spas:

(1) A child's plastic pool shall be drained daily and shall be inaccessible to children when it is not in use. Swimming pools must have a barrier on all sides at least four feet high.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age. Swimming pools must have their methods of access through the barrier equipped with a safety device, such as a bolt lock.

(3) Swimming pools must be equipped with a lifesaving device, such as a ring buoy.

(4) If the swimming pool cannot be emptied after each use, the pool must have a working pump and filtering system.

(5) Hot tubs and spas must have safety covers that are locked when not in use.

The foster parent or other adult shall provide reasonable supervision according to the ages and swimming abilities of the foster children when they are using the pool.

113.5(3) Bedrooms for foster children.

a. Bedrooms shall either have been constructed for the purpose of providing sleeping accommodation or remodeled for sleeping to provide proper heat and ventilation. Bedroom additions to a home shall meet building code requirements. All bedrooms used by foster children shall have:

(1) Permanent walls;

(2) A door that closes;

(3) An unobstructed, operable window that opens from the inside that is large enough to allow for an unrestricted exit by a foster child;

(4) A closet, wardrobe, armoire, or dresser for the child's clothes; and

(5) A standard bed, for infants and toddlers who cannot safely use a standard bed, a crib or crib-like furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the U.S. Consumer Product Safety Commission or ASTM International for juvenile products for each child under two years of age if developmentally appropriate. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Safe infant sleep practices shall conform to the following standards:

1. Infants shall always be placed on their backs for sleep.

2. Infants shall be placed on a firm mattress with a tight fitting sheet that meets U.S. Consumer Product Safety Commission federal standards.

3. Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping. This is not referring to a child in a car seat in a car.

4. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

5. No co-sleeping shall be allowed.

6. If an alternate sleeping position is needed for an infant, a signed authorization with a statement of a medical reason is required and shall be submitted by a physician, advanced registered nurse practitioner, or physician assistant.

b. The minimum bedroom area per child shall be 40 square feet. However, the service area manager or designee may approve a smaller room size when approval is in the best interest of specific children placed or to be placed in the home. Such approvals shall:

(1) Be in writing;

(2) Contain the names and birth dates of the children for whom issued; and

(3) Be reviewed at each license renewal.

c. When bedrooms meet only minimum requirements, the home shall provide additional room in other parts of the home for study and play.

d. The ceiling height for bedrooms shall be adequate for the child.

e. Except for baby video monitors for children birth to two years of age used in their bedrooms, video or surveillance cameras are not allowed in children's bedrooms or bathrooms.

f. Bedrooms belowground shall:

(1) Be free from excessive dampness, noxious gases, and objectionable odors;

(2) Have access to at least one direct exit to the outside from the level belowground and one inside stairway exit from the level belowground;

(3) Have an egress window with a clear opening area with an opening height of 24 inches and an opening width of 20 inches or an opening height of 20 inches and an opening width of 24 inches;

(4) Have provisions, such as a ladder or steps, to ensure that the foster child can safely reach the window if the finished sill height is more than 44 inches above the floor and that the foster child can safely reach ground level if there is a window well that has a depth of 44 inches or higher;

(5) Have a finished ceiling such as drywall or a drop ceiling; and

(6) Have a covered floor.

113.5(4) *All rooms aboveground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(5) *Rooms belowground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(6) *Physical care standards for foster children.*

a. Grouping children in bedrooms shall take into consideration the age and sex of children.

(1) Children over five years of age shall not share a bedroom with a child of the opposite sex.

(2) Foster children shall not share a bed with any other child. The social work administrator may approve a waiver of this policy.

b. Children two years of age or older shall be provided bedroom space other than in the foster parents' bedroom. Foster children under the age of two may share a bedroom with the foster parent in an individual crib.

c. There shall be a plan for isolating healthy children from a child who is ill or suspected of having a contagious disease.

d. The foster home shall provide food with good nutritional content and in sufficient quantity to meet the individual needs of the children.

e. Bedding shall be clean, odor-free, and free of urine and feces.

f. Foster parents shall follow universal precautions to reduce exposure to bloodborne pathogens and other infectious materials when providing care to all children placed in their physical custody.

g. Smoking and vaping shall be prohibited in the foster home or any vehicle when the foster child is present.

113.5(7) *Lead-based paint.* If the applicant lives in a home built before 1960, the applicant shall submit Form 470-4819, Lead Paint Assessment, certifying that the applicant:

a. Has conducted a visual assessment for lead hazards that exist in the form of peeling or chipping paint; and

b. Has applied interim controls using safe work methods if the presence of peeling or chipping paint is found, unless an inspector certified pursuant to department of public health rules at 641—Chapter 70 has determined that the paint is not lead-based. “Interim controls” are measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, such as repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, and temporary containment.

113.5(8) *Artificial lighting.* Adequate artificial lighting fixtures shall be provided for study in areas where children will be studying.

113.5(9) *Bathroom facilities.*

a. Bathroom facilities shall have at least one toilet, sink, and tub or shower in safe operating condition.

b. Bathroom facilities shall have natural or artificial ventilation.

113.5(10) *Heating plant.*

a. The heating plant shall have a capacity to maintain a temperature of approximately 65 degrees Fahrenheit in the bedrooms with the door closed.

b. Fireplaces and water heaters shall be vented to the outside atmosphere. The temperature of any water heaters must be set in accordance with the manufacturer's recommendations. Kerosene heaters and gas-fired space heaters shall not be used to heat any space in the home.

113.5(11) *Ventilation.* Ventilation shall be provided in all rooms where foster children eat, sleep, and play either by windows which can be opened or by mechanical venting systems. Windows and doors used for ventilation shall be screened.

113.5(12) Phone. A working phone or access to a working phone shall be in close walking proximity to an applicant's living space.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 0357C, IAB 10/3/12, effective 12/1/12; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.6(237) Sanitation, water, and waste disposal.

113.6(1) Food preparation and storage. Food preparation areas shall be clean, and the home shall have kitchen facilities with a sink, refrigerator, stove, and oven in safe operating condition.

113.6(2) Public water supply. The water supply is approved when the water is obtained from a public water supply system.

113.6(3) Private water supply.

a. Each privately operated water supply shall be tested prior to initial licensure and tested before license renewal, and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples must be collected and submitted by the licensing worker or health sanitarian to the university hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria. In order to be licensed for the care of children under two years of age the nitrate (NO³) content must be analyzed.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When the water sample result shows the water is potable, the license can be granted.

e. When the water sample is not approved, no foster family home license shall be issued until the foster parents provide a written statement that foster children will be provided potable water, including where the water will be obtained and how it will be transported and stored.

(1) The statement shall be provided on Form 470-0699, Provisions for Alternate Water Supply.

(2) When the family has made ongoing alternative arrangements for the use of safe, potable water, annual testing of the water may be waived after the private water supply has tested unpotable for three consecutive years.

113.6(4) Sewage treatment.

a. Foster homes, wherever possible, shall be connected to public sewer systems.

b. Private disposal systems shall be designed, constructed and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

113.6(5) Garbage storage and disposal.

a. A sufficient number of covered garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, watertight, and rodent proof and shall be maintained in a sanitary condition.

113.6(6) Rodent and insect infestation. The home shall prevent or eliminate rodent and insect infestation.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.7(237) Safety.

113.7(1) Fire protection for bedrooms. Any floor of a house, including the basement, shall be equipped with the following:

a. At least one UL (Underwriter's Laboratory)-approved smoke detector. On floors that are used for sleeping, the smoke detector shall be in a location where sleeping areas can be alerted. For deaf or hard-of-hearing children, the foster parent shall install a smoke detector in the child's bedroom that will use an alternative means of waking the child.

b. Hallways and stairways free of debris and clutter to allow unrestricted access to an exit.

c. A working carbon monoxide detector in all homes with:

- (1) Gas appliances, furnaces, fireplaces, or other gas equipment; and
- (2) Attached garages.

113.7(2) Combustion hazards.

a. Combustible materials shall be kept away from heat sources, including but not limited to furnaces, stoves, electrical panels, space heaters, and hot water heaters.

b. Explosives and flammable substances shall be stored securely and be inaccessible to a child. Matches and lighters shall be inaccessible to a child.

c. The home shall have at least one operable 2A-10BC-rated or ABC-rated fire extinguisher.

113.7(3) Safety plan. The family shall have an emergency safety plan to be used for fire, tornado, blizzard, flood, other natural or manmade disasters, accidents, medical issues, and other life-threatening situations for children in out-of-home placements. The safety plans shall state the action that the foster parents and children are to take in each situation that may occur and shall be posted in a prominent place in the home.

a. The safety plans for fire and tornadoes shall be reviewed with foster children at the time of placement. Fire and tornado plans shall be practiced with the foster children within one week of placement and no less than annually thereafter.

b. In a disaster requiring evacuation of the foster home, the foster parents shall notify the department of the evacuation and the address and telephone number of the foster parents' temporary residence within 24 hours after evacuation.

c. The plans shall include a designated meeting place.

d. Applicants must maintain a comprehensive list of emergency telephone numbers, including poison control, and post those numbers in a prominent place in the home. If there is a landline phone located in the home, the numbers must be posted next to the phone.

113.7(4) Medications, first aid and poisonous substances.

a. All prescription medication shall be administered as prescribed and documented in a medication log that is given to the child's department caseworker when the child leaves the placement.

b. All over-the-counter medications shall be administered according to label directions or as directed by a physician.

c. Applicants must prevent the child's access, as appropriate for the child's age and development, to all medications, poisonous materials, cleaning supplies, other hazardous materials and alcoholic beverages.

d. Applicants must maintain first aid supplies as recommended by the American Red Cross.

113.7(5) Weapons. All weapons, firearms, and ammunition shall be inaccessible to a child of any age.

a. The following weapons must be stored in an inoperative condition in a locked area inaccessible to children:

- (1) Firearms;
- (2) Air guns;
- (3) BB guns;
- (4) Hunting slingshots;
- (5) Any other projectile weapons.

b. All ammunition, arrows or projectiles for such weapons shall be maintained in a locked place separate from the firearms.

c. The weapons, firearms, and ammunition storage unit shall not share the same key or matching security code. If a key is used, the key shall be stored in a place inaccessible to the foster child.

d. Any motor vehicles used to transport foster children shall not contain a loaded gun, and any ammunition in the vehicle shall be kept in a separate, locked container.

e. Foster parents who have a permit to carry a firearm shall sign Form 470-4657, Firearms Safety Plan. Foster parents who have firearms but do not have a permit to carry shall complete the safety plan section of the Firearms Safety Plan form.

f. Foster parents who are also law enforcement officials and can document that their jurisdiction requires them to have ready and immediate access to their weapons may be exempt from these weapon requirements provided they adopt and follow a safety plan approved by the department.

113.7(6) *Transporting foster children.*

a. Foster parents will ensure that if a privately owned vehicle, owned by the applicants, family or friends, is used to transport the child in foster care, it must be inspected (if applicable under state law), registered, and insured and meet all applicable state or tribal requirements to be an operable vehicle on the road.

b. The driver will have a valid Iowa driver's license.

c. Safety restraints will be used that are appropriate to the child's age, height, and weight.

d. Any motor vehicles used to transport foster children shall be smoke-free when foster children are being transported.

e. Weapons must not be transported in any vehicle in which the child is riding unless the weapons are made inoperable and inaccessible.

f. Foster parents will have access to reliable public transportation if they do not have access to a reliable, registered, and insured vehicle.

113.7(7) *Supervision.* The foster parents shall provide reasonable and prudent supervision of foster children to ensure their safety.

a. Foster parents shall adequately supervise foster children while the children are using any hazardous or dangerous objects or equipment. In order for foster children to participate in age- or developmentally appropriate activities, the foster parent would apply the reasonable and prudent parent standard.

b. Foster parents shall use reasonable and prudent supervision of foster children when the foster children are using the Internet or other social media.

113.7(8) *Household pets.* Household pets and any outdoor animals or pets accessible to foster children shall have a current veterinary health certificate verifying that the animal's routine immunizations, e.g., rabies, are current.

a. At the time of the initial home study and any time thereafter, foster parents shall report an animal's history of aggression towards people and inform the department of the animal's aggression towards people within 24 hours of an occurrence.

b. Foster parents who have pets or animals with any history of aggression shall have a written plan that addresses strategies to reduce the risk of aggression by their pets or animals with which the child will have contact.

c. Animal waste will be contained and disposed of on a routine basis.

113.7(9) *Liability.* Foster parents who apply the reasonable and prudent parent standard reasonably and in good faith in regard to a foster child placed in their home shall have immunity from civil or criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 0357C, IAB 10/3/12, effective 12/1/12; ARC 2743C, IAB 10/12/16, effective 12/1/16; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—113.8(237) Foster parent training.

113.8(1) *Preservice training.* All foster parent applicants shall complete the following training before licensure and the placement of a child in foster care in their home:

a. Orientation pursuant to rule 441—117.2(237);

b. Preservice training pursuant to rule 441—117.1(237);

c. Preservice training, which shall include:

- (1) An agency-approved medication management training,
- (2) A face-to-face cardiopulmonary resuscitation (CPR) and first-aid training,
- (3) Mandatory reporter training on child abuse identification, and
- (4) The reasonable and prudent parent standard training; and

d. Mandatory reporter training on child abuse identification and reporting before initial licensure and every three years thereafter as required by rule 441—112.10(232) and 441—subrule 117.8(3).

113.8(2) *In-service training.* All licensed foster parents shall complete six hours of in-service training annually as required by rule 441—117.7(237).

Each foster parent shall maintain certification in CPR and first-aid training.

This rule is intended to implement Iowa Code section 237.5A.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 2069C, IAB 8/5/15, effective 10/1/15; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5361C, IAB 12/30/20, effective 3/1/21]

441—113.9(237) Involvement of kin.

113.9(1) *Support by foster parents.* Foster parents shall support the involvement of biological or adoptive parents and other relatives of the foster child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

113.9(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the foster parents, biological or adoptive parents, and others involved with the child and family.

113.9(3) *Cultural connections.* Throughout the provision of care, the foster family shall actively ensure that the foster child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

441—113.10(237) Information on the foster child.

113.10(1) *Foster child information.* Foster parents shall maintain a separate folder of information on each foster child placed in the foster family home. This folder shall be provided to the department or the child's parent or guardian when the child leaves the placement. The folder shall contain:

a. The names and addresses of all doctors, mental health professionals, and dentists who have treated the foster child; current medications prescribed, including over-the-counter medications; medication log; and the type of medical, dental, vision, and mental health treatments and hearing examinations received while the foster child is in the foster home.

b. School reports including report cards and pictures.

c. Date the child left the placement.

d. Name, address, and telephone number of the person to whom the child is discharged.

113.10(2) *Confidentiality.* Foster parents shall maintain confidentiality regarding a child in placement except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Foster parents shall not without parent or guardian and department consent post pictures or information concerning a foster child on any Internet Web site or on social media.

This rule is intended to implement Iowa Code section 237.7.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.11(237) Health of foster family.

113.11(1) *Health report required.* The foster parents shall furnish the licensing agency with a health report on the family completed no more than six months before the application for licensure. The report shall include information on all family members, including foster parents, their minor children who reside in the home, and adult household members. An updated report shall be provided upon request of the department licensing worker or the recruitment and retention contractor.

113.11(2) *Contents of report.* This report shall include a statement from the health practitioner that there are no physical or mental health problems which would be a hazard to foster children placed in the home and a statement that the foster parents' health would not prevent needed care from being provided to the child.

113.11(3) *Whooping cough vaccine.* All household members who are caregivers must have up-to-date whooping cough vaccines unless contrary to the person's health.

113.11(4) *Capability for caring for the child.* If there is evidence that the foster parent is unable to provide necessary care for the child, the department licensing worker, the recruitment and retention contractor, or the physician may require additional medical and mental health reports, including a substance abuse evaluation.

This rule is intended to implement Iowa Code section 237.7.
[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.12(237) Characteristics of foster parents.

113.12(1) *Age.*

- a. Foster parents shall be at least 21 years of age.
- b. The age of foster parents shall be considered as it affects their ability to care for a specific child and function in a parental role.

113.12(2) *Income and resources.* The foster family shall have sufficient income and resources to provide adequately for the family's own needs.

113.12(3) *Religious considerations.* The foster parent shall respect the foster child's religious background and affiliation.

113.12(4) *Requirements of foster parents.* Foster parents shall be stable, responsible, physically able to care for the type of child placed, mature individuals who are not unsuited by reason of substance abuse, lewd or lascivious behavior or other conduct likely to be detrimental to the physical or mental health or morals of the child. They shall exercise good judgment in caring for children and have a capacity to accept agency supervision.

113.12(5) *Personal characteristics.* The foster parents shall:

- a. Provide evidence of relationship stability.
- b. Have realistic expectations of foster children.
- c. Have time available to parent foster children.
- d. Be able to communicate with the licensing agency and health care and other service providers.
- e. Have functional literacy, a level of reading, writing and calculation skills such as having the ability to read labels on medications in order to properly administer them.
- f. Be able to accept and deal with acting out behavior with realistic expectations and good judgment.
- g. Include foster children in normal family life.
- h. Have the ability to be accepting and loving toward a foster child entering the home.
- i. Be able to support the case permanency plan for the foster child and be willing to cooperate with visits, transportation, or other activities that support the child's connection to and reunification with the child's family.
- j. Ensure that all family members are aware of having foster children in the home.
- k. Articulate their strengths and concerns and limitations which are essential to the department's matching the foster children with foster parents appropriately.

113.12(6) *Determination of characteristics.* The areas discussed in subrules 113.12(4) and 113.12(5) shall be explored through observation of the family and interviews with family members and documented in a foster home study as described in subrule 113.3(4), or in the foster family record when explored after licensure and prior to renewal. Any additional areas that the family or worker identifies as a possibility for creating problems shall also be documented in the foster family record.

This rule is intended to implement Iowa Code section 237.3.
[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.13(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 14 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse reports or criminal convictions or has been placed on the sex offender registry.

113.13(1) *Procedure.* The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting.

a. Iowa records. Each foster parent applicant and anyone who is 14 years of age or older living in the home of the applicant shall be checked for records with:

- (1) The Iowa central abuse registry, using Form 470-0643, Request for Child and Dependent Adult Abuse Information;
- (2) The Iowa division of criminal investigation, using Form 595-1396, DHS Criminal History Record Check, Form B;
- (3) The Iowa sex offender registry; and
- (4) Iowa Courts Online.

b. Other records.

(1) Each foster parent applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years.

(2) Each foster parent applicant shall also be fingerprinted for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required on all other adult household members at the time of initial application effective with applications dated on or after October 1, 2011. When warranted, the department may require fingerprinting for a national criminal history check on adult household members who move in after initial application.

113.13(2) Evaluation of record. If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall not license the applicant as a foster family unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of license.

a. Exclusion. An evaluation shall not be performed if the person has been convicted of:

- (1) A felony offense as set forth in Iowa Code section 237.8(2)“a”(4); or
- (2) A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)“a”(4).

b. Scope. The evaluation shall consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

- (1) The position sought or held,
- (2) The time elapsed since the abuse or crime was committed,
- (3) The degree of rehabilitation,
- (4) The likelihood that the person will commit the abuse or crime again, and
- (5) The number of abuses or crimes committed by the person.

c. Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date of receipt to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of licensure.

113.13(3) Evaluation decision. The service area manager or designee shall conduct the evaluation and make the decision. The department shall issue Form 470-2310, Record Check Evaluation, to inform the subject of the decision and describe the basis of the decision using the criteria specified in paragraph 113.13(2)“b.” The department shall mail the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed Form 470-2310, Record Check Evaluation, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified in paragraph 113.13(2)“c.”

113.13(4) License renewal. Foster parents applying for an annual or biennial license renewal shall be subject to the same checks as new applicants, except for fingerprinting. The department shall evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation shall be conducted using the same process.

This rule is intended to implement Iowa Code section 237.8(2).

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 0356C, IAB 10/3/12, effective 12/1/12; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.14(237) Reference checks.

113.14(1) At least three additional unsolicited references shall be checked for all foster family home applicants in addition to a minimum of three references provided by the applicant. Required references shall include a minimum of one relative and one nonrelative.

113.14(2) Responses of references shall be documented in the applicant's record.

113.14(3) Information received from references may be discussed with the applicant at the discretion of the worker. The reference shall be so informed.

113.14(4) Reference checks shall include only those areas related to the applicant's ability to care for children and should include discussion of the following areas:

- a. How long and in what capacity the reference has known the applicant.
- b. Personal qualities of the applicant including the general character, ability to get along with others, ability to deal with children's problem behavior, ability to give affection and care, discussion of use of drugs and alcohol, questions regarding personal difficulties that could be detrimental to a foster child.
- c. Relationship stability.
- d. How the applicant handles anger, problems, crisis situations, discipline, and disappointments.
- e. Any areas of general concern not previously mentioned.
- f. Would the reference feel comfortable leaving a child in this home for a period of time?
- g. Recommendations regarding licensing.

113.14(5) When warranted, additional references may be sought after licensure.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17; ARC 5064C, IAB 7/1/20, effective 9/1/20]

441—113.15(237) Unannounced visits.

113.15(1) The department's recruitment and retention contractor shall make unannounced visits during periods of the day when the child and foster parents would normally be at home and awake, unless there has been a specific complaint about the family and care of the child.

113.15(2) The unannounced visit shall include, but is not limited to, assessment of the following areas:

- a. Home environment.
- b. Who was present at the time of the visit.
- c. Interaction between the foster child and foster family and their children.
- d. The foster child's perception of the foster parents, other children and adults in the home, behavioral expectations of foster parents, discipline used by foster parents, religious training, school, contact with natural parents, and purpose of placement in foster care.
- e. The foster parents' view of the child, the child's problem, placement worker's involvement, plan for the child, involvement of natural parents, and additional services that either the foster child or foster parents need.
- f. Any previously or currently cited deficiencies, corrective action plans and progress.
- g. Any previous or current concerns from department workers.
- h. Discussion of placements during the licensing year and, if none, the reason why.
- i. Progress on completing training in the foster parents' training plan.
- j. Awareness of the foster parents' license capacity and compliance.
- k. Recommended action.

113.15(3) An unannounced visit to the foster home:

- a. Shall be completed annually;
- b. Shall not be waived; and
- c. Shall not occur in conjunction with license renewal.

113.15(4) The findings from the unannounced visit shall be summarized on Form 470-5438, Progress Notes.

- a. The report shall be sent to the department licensing worker and the foster parents within two weeks after the visit.
- b. A copy of the report shall be retained in the foster parents' record.

113.15(5) Actions after the unannounced visit.

- a. When deficiencies are cited that do not appear likely to cause immediate physical or mental harm to the child, an additional visit may be scheduled. The department licensing worker and the

recruitment and retention contractor shall discuss the deficiencies with the foster parents and make plans for improving the deficiencies.

b. When the reported deficiencies raise questions of concern as to the quality of care provided, the recruitment and retention contractor shall:

(1) Report deficiencies to the department licensing worker and to the placement worker for each foster child currently placed in the home;

(2) Hold a meeting with the department licensing worker and the foster parents to discuss deficiencies and the plans for improving the deficiencies and then complete a written corrective action plan as to how the foster parents intend to address the deficiencies.

c. When the reported deficiencies appear likely to cause immediate physical or mental harm to the child, the service area manager or designee shall immediately:

(1) Direct the placement worker to determine if the child should be removed, and

(2) Direct the licensing worker to complete a review of the foster home to determine if the family should continue to be licensed, should receive a provisional license, or should have the license revoked according to 441—112.6(237).

113.15(6) When the foster parents refuse to make a written commitment to improve the deficiencies, the department licensing worker shall conduct a complete review of the foster home to determine if the license should be revoked according to rule 441—112.6(237).

This rule is intended to implement Iowa Code section 237.7.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.16(237) Planned activities and personal effects.

113.16(1) *Daily routine.* The daily routine shall promote good health and provide an opportunity for activity suitable for the foster child with time for rest and play.

113.16(2) *Clothing.*

a. All children should have their own clothing.

b. Children shall have training and help in selection and proper care of clothing.

c. Clothing shall be suited to the existing climate and seasonal conditions.

d. Clothing shall be becoming, of proper size, and culturally appropriate.

e. There shall be an adequate supply of clothing to permit laundering, cleaning and repair.

f. There shall be adequate closet and drawer space for children to permit access to their clothing.

113.16(3) *Educational opportunity.* Every foster child shall be given the opportunity to complete high school or vocational training in accordance with the child's case permanency plan. The foster parent shall be an advocate for the foster child by working with the foster child's school.

113.16(4) *Religion and culture.* Each child shall be given an opportunity, in consultation with the child's parents, to participate in the child's culture and religion. Children shall not be required to participate in religious training or observances contrary to the wishes of the biological or adoptive family or the religious beliefs of the child.

113.16(5) *Community participation.* Every child shall be given the opportunity to develop healthy social relationships through participation in neighborhood, school and other community and group activities. The child shall have the opportunity to invite friends to the foster home and to visit the home of friends.

113.16(6) *Work assignments.* Work assignments shall be in keeping with the child's age and development.

a. Exploitation of the child is prohibited. No child shall be permitted to do any hazardous tasks or to engage in any work which is in violation of the child labor laws of the state.

b. Each child shall have the opportunity to learn to assume some responsibility for self and for household duties in accordance with the child's age, health and ability. However, assigned tasks shall not deprive the child of school, sleep, play or study periods.

This rule is intended to implement Iowa Code section 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.17(237) Medical examinations and health care of the child.

113.17(1) *Medical and dental care.* Foster parents shall keep the child's department case manager informed of any medical and dental appointments and treatments prescribed for the child.

a. Foster parents shall contact the child's parents to engage them in the process of accessing routine medical and dental care for their child unless parental rights have been terminated.

b. In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of a child, when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child, the foster parents can provide consent for medical care and treatment.

113.17(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization which is against medical treatment for disease. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

This rule is intended to implement Iowa Code section 237.3.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.18(237) Training and discipline of foster children.

113.18(1) *Foster parents' methods of training and discipline.* The home study evaluation of each foster parent applicant shall include a discussion and a written report of the foster parents' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

113.18(2) *Restrictions on training and discipline.* Child training and discipline shall be handled with kindness and understanding.

a. A child shall not be locked in a room, closet, box, or other device.

b. No child shall be deprived of food as punishment.

c. No child shall be subjected to verbal abuse, threats or derogatory remarks about the child or the child's family.

d. The use of corporal punishment is prohibited.

e. Restraints shall not be used as a form of discipline.

(1) Reasonable physical force may be used to restrain a child only in order to prevent injury to the child, injury to others, the destruction of property, or extremely disruptive behavior.

(2) Upon approval of the department, the foster parent may use restraints only in accordance with the written plan of a licensed mental health professional who is working with the child and the foster parents.

113.18(3) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department licensing worker and caseworker for the foster child shall be investigated promptly and referred to the proper authorities when necessary.

This rule is intended to implement Iowa Code sections 234.40 and 237.3.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 3185C, IAB 7/5/17, effective 9/1/17]

441—113.19(237) Emergency care and release of children.

113.19(1) *Supervision and arrangements for emergency care.*

a. Foster parents shall provide supervision of foster children and children in preadoptive placement as dictated by the individual child's specific needs.

b. In case of emergency requiring the foster parents' temporary absence from the home, arrangements shall be made with other licensed foster parents or with designated, responsible persons

for the care of the children during the period of absence. The child's placement worker shall be notified of all emergency absences of the foster parents.

113.19(2) Release of foster child. The foster parents shall release the foster child only to the agency, parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

This rule is intended to implement Iowa Code section 237.3.
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

441—113.20(237) Changes in foster family home. Foster parents shall notify the department and the recruitment and retention contractor within seven working days of:

1. Any change in the number of persons living in the home (except for foster children);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of a child in the family's care.

This rule is intended to implement Iowa Code section 237.3.
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[◇] Two or more ARCs

CHAPTER 40
BOATING SPEED AND DISTANCE ZONING
[Prior to 12/31/86, Conservation Commission[290] Ch 30]

571—40.1(462A) Restricted areas. All vessels, except authorized emergency vessels, shall be operated in compliance with, and all persons engaged in water recreation activities, shall obey restrictions with posted areas marked with a uniform waterway buoy or official signs adopted by the natural resource commission.

571—40.2(462A) Uniform buoy system. All buoys placed shall be those of the uniform waterway marking system adopted by the natural resource commission and shall be constructed, placed, and maintained in accordance with Iowa Code chapter 462A and Iowa Administrative Code 571—Chapters 40 and 41.

571—40.3(462A) Commission approval. The placement of buoys or official signs that restrict speed and distance or involve special zoning restrictions shall be approved by the natural resource commission.

571—40.4(462A) Right for aggrieved party to appeal. Any finding or establishment of areas involving special speed and distance or zoning restrictions by the natural resource commission may be appealed by aggrieved party upon written notice. A hearing thereon shall be held by the natural resource commission within 30 days thereafter.

571—40.5(462A) Rathbun Lake, Appanoose County—zoned areas.

40.5(1) Areas may be specifically designated for swimming and wading.

40.5(2) Areas may be designated restricted speed areas.

40.5(3) Areas may be designated as “no anchoring” areas.

40.5(4) Areas may be designated as “no boating” areas.

[ARC 5176C, IAB 9/9/20, effective 10/14/20]

571—40.6(462A) Red Rock Lake, Marion County—zoned areas.

40.6(1) Areas may be specifically designated for swimming and wading.

40.6(2) Areas may be designated restricted speed areas.

40.6(3) Areas may be designated as “no anchoring” areas.

571—40.7(462A) Coralville Lake, Johnson County—zoned areas.

40.7(1) Areas may be specifically designated for swimming and wading.

40.7(2) Areas may be designated restricted speed areas.

571—40.8(462A) Saylorville Lake, Polk County—zoned areas.

40.8(1) Areas may be specifically designated for swimming and wading.

40.8(2) Areas may be designated restricted speed areas.

571—40.9(462A) Lake Odessa in Louisa County.

40.9(1) Areas may be designated restricted speed areas.

40.9(2) All motorboats, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour year around, on that portion of Lake Odessa known as the Sand Run Chute, lying south of the main lake to a point 100 yards south of the Sand Run Chute boat ramp.

40.9(3) All motorboats, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour year around, on those portions of Lake Odessa known as the lateral ditch, between the main lake and Bebee Pond, and on the channel between Yankee Chute and Beaver Pond.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.10(462A) Mississippi River lock and dam safety zone. A safety zone is hereby established in Iowa waters above and below all navigation lock and dam structures on the Mississippi River between the

Iowa-Minnesota border and the Iowa-Missouri border. The established zone shall be 600 feet upstream and 150 feet downstream from the roller gate or tainter gate section of the structure.

40.10(1) The safety zone does not include the area directly above and below the navigation lock structure.

40.10(2) The safety zone does not include the area directly above and below the solid fill portion of the dam and structure.

40.10(3) The safety zone shall be recognized by the state of Iowa only when plainly marked as follows:

- a. Upstream signs worded—Restricted area keep 600 feet from dam.
- b. Downstream signs worded—Restricted area keep 150 feet from dam.
- c. Flashing red lights will be used to make the outer limits of the restricted areas.

40.10(4) No boat or vessel of any type, except authorized vessels, shall enter the established safety zones recognized by the state of Iowa as described in this rule.

571—40.11(462A) Joyce Slough Area. The Joyce Slough Area, a portion of the Mississippi River within the city of Clinton, Iowa, is hereby zoned to be a harbor area and vessels traveling therein shall not travel at speeds in excess of five miles per hour.

571—40.12(462A) Swan Slough, Camanche, Iowa. A restricted speed zone of not greater than 5 miles per hour is hereby established in all or part of the main channel of Swan Slough (Mississippi River mile 510.2 to 511.3), Camanche, Iowa, as designated by buoys.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.13(462A) Massey Slough. The operation of vessels in Massey Slough of the Mississippi River at Massey Station, Dubuque County, Iowa, extending from a northerly to southerly direction from the upper end to the lower end of the slough, encompassing the water in Section 14, Township 88N, Range 3E of the 5th P.M., tract number NFIA-26M, is restricted as follows:

40.13(1) All boats underway must maintain a speed of less than five miles per hour in said waters.

40.13(2) Reserved.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.14(462A) Black Hawk County waters. Operation of vessels in Black Hawk County on the Cedar River and any connected backwaters shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.14(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys, signs, or other approved uniform waterway marking devices marking the area.

40.14(2) All vessels, except authorized emergency vessels, shall be operated at a speed not greater than 5 miles per hour when within 600 feet of the Franklin Street bridge. This 600-foot zone shall be designated by buoys, signs, or other approved uniform waterway marking devices.

40.14(3) No vessel shall tow skiers, surfboard riders, or other towable devices within the zone established by 40.14(2).

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.15(462A) Mitchell County waters. Operation of vessels in Mitchell County is restricted to speeds not greater than 5 miles per hour where a speed zone is designated by buoys on the following impounded waters:

Cedar River from Mitchell Dam, thence upriver to the County “S” bridge.

Cedar River from the St. Ansgar Mill Dam, thence upriver to the Newberg Bridge crossing Highway 105.

Cedar River from the Otranto Dam upriver to the Great Western Railway Bridge crossing the Cedar River.

The Stacyville Pool, on the Little Cedar River at Stacyville, Iowa.

40.15(1) Water recreation activities as restricted within posted areas which are marked with approved buoys shall be obeyed.

40.15(2) Reserved.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.16(462A) Maquoketa River. Operation of vessels of the impoundment of the Maquoketa River in Delaware County, Iowa, extending westerly and northerly from the line between Sections 29 and 30 in Delhi Township in said county, to the line between Sections 10 and 15 in Milo Township in said county which impoundment is sometimes known and referred to as Hartwick Lake or Lake Delhi.

40.16(1) Water recreation activity restrictions shall be obeyed, including restrictions within posted areas which are marked with approved buoys.

40.16(2) No motorboat shall be operated at speeds greater than ten miles per hour at any time between the hours from one hour after sunset to one hour before sunrise.

571—40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County. No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area designated by regulatory buoys or signs on the off-channel waters of the Wapsipinicon River above the dam at Central City, Linn County, Iowa.

The zoned area will be the off-channel waters created in and adjacent to the developed recreation areas of the Pinicon Ridge Park on the west and south bank of the Wapsipinicon River above the dam at Central City, Linn County.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.18(462A) Speed restrictions on Lake Manawa. No motorboat shall be operated at a speed greater than five miles per hour within the zoned areas 300 feet from shore around Lake Manawa in Pottawattamie County.

571—40.19(462A) Zoning of Little Wall Lake. No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area designated by regulatory buoys on Little Wall Lake in Hamilton County.

The zoned area will not exceed approximately 20 acres in the northeast portion of the lake identified by a line from a point on the high-water mark approximately 296.6 feet west of the southeast corner of the southwest quarter of Section 10, Township 86 North, Range 24 West; thence northwest to the high-water mark which is 775 feet south and 319 feet west of the northeast corner of the northwest quarter of the southwest quarter of Section 10, Township 86 North, Range 24 West.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.20(462A) Lake Icaria, Adams County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Lake Icaria. The following rules shall govern vessel operation on Lake Icaria in Adams County.

40.20(1) All vessels shall be operated at a speed not greater than 5 miles per hour when within 50 feet of another vessel which is not underway or is operating at a no-wake speed.

40.20(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys or signs in accordance with 571—Chapter 41.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. Said buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by uniform marker buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50

feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.21(462A) Zoning of the Des Moines River. Vessel operation on the Des Moines River from its confluence with the Mississippi River in Lee County to the northerly meander lines of both the East and West Branches, shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.21(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys marking said areas.

40.21(2) No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys.

571—40.22(462A) Upper Gar Lake, Dickinson County. Operation of vessels on Upper Gar Lake is restricted to a speed not greater than 5 miles per hour between the Henshaw Bridge at the north end of Upper Gar and south end of East Lake and the Old Sawmill Bridge at the south end of Upper Gar and the north end of Minnewashta.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.23(462A) Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County.

40.23(1) All vessels operated between the ice dike and Bussey Lake access shall be operated at a speed not greater than 5 miles per hour.

40.23(2) The city will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.24(462A) Mt. Ayr City Lake (Loch Ayr). A motorboat shall not be operated within 100 feet of shore at a speed greater than 5 miles per hour.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.25(462A) Iowa River in Iowa City, Johnson County. No person shall operate any vessel towing persons on water skis, surfboards, or similar devices on the Iowa River in the area bounded by the Coralville Mill Dam and the Burlington Street Dam, except during regattas, races, marine parades, tournaments, or exhibitions authorized by the natural resource commission to be held in such area.

571—40.26(462A) Zoning of the Mississippi River, Dubuque, Dubuque County.

40.26(1) All vessels shall be limited to no more than five miles per hour in Lake Peosta Cut south and east of the Hawthorn Street municipal boat launching ramp.

40.26(2) A restricted speed zone of no more than 5 miles per hour is established in the vicinity of Chaplain Schmitt Memorial Island in proximity to the Schmitt Island municipal launching ramp and in waters adjacent to the southerly shoreline in the area of the Dubuque Yacht Basin.

40.26(3) A restricted speed zone of five miles per hour for the northern portion of Shawondassee Slough. Marker buoys shall be placed at a point approximately 750 feet upstream from the existing speed zone.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.27(462A) Zoning Harpers Slough, Harpers Ferry, Allamakee County.

40.27(1) All vessels operated in Harpers Slough between a point 200 feet above the state ramp and 200 feet out from the west shore and extending 550 feet downstream from a point known as Sandy Point Road Dead-End shall operate at a speed not greater than 5 miles per hour.

40.27(2) The city of Harpers Ferry will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10; ARC 0111C, IAB 5/2/12, effective 4/13/12]

571—40.28(462A) Black Hawk Lake, Sac County—zoned areas.

40.28(1) No motorboat shall be operated at a speed greater than 5 miles per hour within the zoned area marked by the regulatory buoys. The zoned area shall be the area commonly known as Town Bay on the northwest corner of Black Hawk Lake in Sac County.

40.28(2) Areas may be specifically designated for swimming by the use of regulatory buoys.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.29(462A) Speed and other restrictions on Brown’s Lake, Woodbury County. All vessels shall be operated at a speed not greater than 5 miles per hour within the two zoned areas designated by regulatory buoys or other approved uniform waterway markers.

40.29(1) Zone 1. Zone 1 shall extend 570 yards from the boat ramp east to the regulatory buoys and 150 yards west from the boat ramp.

40.29(2) Zone 2. Zone 2 shall begin at the regulatory buoys located at the 24-inch steel pipe and shall extend west.

40.29(3) Swimming. Areas may be specifically designated for swimming by the use of regulatory buoys.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.30(462A) Speed and other restrictions on Snyder Bend Lake, Woodbury County. All vessels shall be operated at a speed not greater than 5 miles per hour within the zoned area 400 yards from the boat ramp south to the regulatory sign and buoys.

Areas may be specifically designated for swimming by the use of regulatory buoys.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.31(462A) Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County. No motorboat shall be operated at a speed greater than 5 miles per hour within the three zoned areas designated by regulatory buoys on East Okoboji and West Okoboji Lakes in Dickinson County.

40.31(1) Zone 1. Zone 1 shall be a line from the east side of Givens Point to the south end of Arnolds Park City Beach on West Okoboji. Also, a line 150 yards east from the north end of the railroad trestle bridge at Clair Wilson State Park south to the shoreline of East Okoboji.

40.31(2) Zone 2. Zone 2 shall be the area which is 300 feet north of the area commonly known as the Narrows on East Okoboji and extends to a southern boundary of a buoy line from the point at 16486 255th Avenue east to the state property adjacent to 16313 256th Avenue on the east side of East Okoboji.

40.31(3) Zone 3. Zone 3 shall be the area 50 feet east of the bridge between East Okoboji and Upper Gar on the East Okoboji side running in a northwesterly direction toward the end of the island from Gingles Point then west toward the shoreline.

40.31(4) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.31(5) The following areas are zoned 5 miles per hour on West Okoboji.

a. Zone 1. Zone 1 shall be the area commonly known as Okoboji Harbor at the northwest corner of West Okoboji.

b. Zone 2. Zone 2 shall be the area commonly known as the canals in the city of Wahpeton including Turtle Lake.

c. Zone 3. Zone 3 shall be the area commonly known as Lazy Lagoon located in the Triboji Area on West Okoboji.

d. Zone 4. Zone 4 shall be the area commonly known as Little Millers Bay. The zone shall start at Pinkies Point and extend southeasterly (160 degrees) approximately 370 yards until bisecting the southern shoreline of Little Millers Bay.

e. Zone 5. Zone 5 shall be the area commonly known as Little Emmerson Bay. The zone shall start at Breezy Point and extend southwesterly (235 degrees) approximately 330 yards until bisecting the west shoreline of Little Emmerson Bay.

[ARC 8877B, IAB 6/30/10, effective 8/4/10; ARC 5799C, IAB 7/28/21, effective 9/1/21]

571—40.32(462A) Spirit Lake, Dickinson County—zoned areas.

40.32(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.32(2) The following areas are zoned 5 miles per hour on Spirit Lake, Dickinson County:

- a. Zone 1 shall be the area commonly known as Templar Park Lagoon located midlake on the west shore of Spirit Lake.
- b. Reserved.

571—40.33(462A) Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park. No motorboat shall operate at a speed to exceed 5 miles per hour within the area designated by buoys or other approved uniform waterway markers, beginning at the entrance of Spruce Creek harbor and extending southeast 550 feet and extending east 150 feet from shore. The Jackson County conservation board will designate the speed zone with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.34(462A) Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula. No motorboat shall operate at a speed to exceed five miles per hour within the four zoned areas designated by buoys or other approved uniform waterway markers.

40.34(1) Zone 1. Zone 1 shall extend 200 feet from shore and begin at a point 250 feet upstream of the north Sabula city boat ramp and ending at a point downstream where Bank Street intersects the river bank.

40.34(2) Zone 2. Zone 2 shall extend 200 feet from shore and extend 100 feet upstream and 100 feet downstream from the entrance to the Island City Harbor.

40.34(3) Zone 3. Zone 3 shall extend 200 feet into South Sabula Lake from the county boat ramp and 100 feet to the west of the ramp and 600 feet to the east of the ramp.

40.34(4) Zone 4. Zone 4 shall extend 200 feet in all directions beginning at the center of the “cut” into Lower Sabula Lake.

The city of Sabula shall designate the speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.35(462A) Speed restrictions on the Greene Impoundment of the Shell Rock River. No motorboat shall be operated at a speed exceeding five miles per hour in the two zoned areas of the Greene Impoundment designated by buoys or other approved uniform waterway markers. The first zoned area extends from the dam in the city of Greene, upstream approximately one-quarter mile to the north boundary of the city park in which the lower boat ramp is located. The second zoned area extends from the county bridge over the Shell Rock River on the north side of section 28 of Union Township in Floyd County, downstream approximately one-quarter mile to the south boundary of Gates Bridge County Park. The city of Greene and Floyd County shall designate their respective speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.36(462A) Zoning of the Iowa River, Iowa Falls, Hardin County.

40.36(1) All vessels operated in a designated zone between the River Street Bridge and the dock at Dougan’s Landing shall be operated at a speed not greater than 5 miles per hour.

40.36(2) The city of Iowa Falls shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

40.36(3) All vessels operated in a designated zone beginning at the west property boundary and ending at the east property boundary of the Scenic City Empress Boat Club property located at 1113 Union Street shall be operated at a no-wake speed. The zone shall not extend more than 75 feet into the Iowa River channel.

40.36(4) The Scenic City Empress Boat Club shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10; ARC 3931C, IAB 8/1/18, effective 9/5/18]

571—40.37(462A) Zoning of Crystal Lake. No motorboat shall be operated at a speed greater than 5 miles per hour within the 25-acre zoned area designated by regulatory buoys on Crystal Lake in Hancock County.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.38(462A) Five Island Lake, Palo Alto County.

40.38(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.38(2) Reserved.

571—40.39(462A) Lost Island Lake, Palo Alto and Clay Counties.

40.39(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.39(2) Reserved.

571—40.40(462A) Ingham Lake, Emmet County.

40.40(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.40(2) Reserved.

571—40.41(462A) Storm Lake, Buena Vista County.

40.41(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.41(2) Reserved.

571—40.42(462A) Raccoon River Regional Park Lake, Polk County.

40.42(1) All vessels shall be operated at a speed not greater than 5 miles per hour.

40.42(2) A 40-acre body of water located in the southeast corner, and separate from the main lake, shall be designated for nonmotorized and electric motors only. The city of West Des Moines will designate the area with regulatory buoys and signs.

40.42(3) Areas may be specifically designated for swimming by the use of regulatory buoys.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.43(462A) Zoning of the Mississippi River, Bellevue, Jackson County.

40.43(1) All vessels shall be operated at a speed not greater than 5 miles per hour within the area designated by buoys or other approved uniform waterway markers beginning at the mouth of Mill Creek and extending upstream 900 feet, and extending 200 feet perpendicular from shore. The area shall be designated by a minimum of four approved buoys to be uniformly placed along the 900-foot length of the zone parallel to the shore.

40.43(2) The city of Bellevue will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.44(462A) Three Mile Lake, Union County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Three Mile Lake. The following rules shall govern vessel operation on Three Mile Lake in Union County.

40.44(1) All vessels shall be operated at a speed not greater than 5 miles per hour when within 50 feet of another vessel which is not underway or is operating at a speed not greater than 5 miles per hour.

40.44(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by use of regulatory buoys in accordance with Iowa Administrative Code 571—Chapter 41. The Union County conservation board shall designate and maintain a swimming area(s) by the use of regulatory buoys approved by the natural resource commission.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. No motorboats, except authorized emergency vessels, shall be operated other than at a speed not greater than 5 miles per hour

above a line of buoys placed across the lake at the point where County Road H33 intersects the lake. All buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by regulatory buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50 feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.45(462A) Zoning of the Cedar River.

40.45(1) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending east 150 feet from the intersection of Wabash Street and Charles City Road and north 380 feet shall be operated at a speed not greater than 5 miles per hour. The city of Nashua shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

40.45(2) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending north 131 feet from the intersection of Wabash Street and the north entrance to Cedar View Circle and east 80 feet and west 80 feet from this point along the shoreline and extending 110 feet north into the lake shall be operated at a speed not greater than 5 miles per hour. The city of Nashua shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.

40.45(3) *Charles City, Floyd County.* All vessels operated in a designated zone extending 300 feet upstream from the upper dam shall be operated at a speed not greater than five miles per hour. The city of Charles City shall designate and maintain the five miles per hour speed zone with marker buoys approved by the natural resource commission.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.46(462A) Zoning of Carter Lake, Pottawattamie County.

40.46(1) All vessels operated in a designated zone known as Shoal Pointe Canal shall be operated at a speed not greater than 5 miles per hour.

40.46(2) The city of Carter Lake shall designate and maintain the 5-mile-per-hour speed zone with marker buoys approved by the natural resource commission.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.47(462A) Zoning of the Mississippi River, McGregor, Clayton County.

40.47(1) All vessels, except commercial barge traffic, shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 634 and 633.4 and designated by buoys or other approved uniform waterway markers.

40.47(2) The city of McGregor will designate the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.48(462A) Zoning of the Mississippi River, Marquette, Clayton County.

40.48(1) All vessels, except commercial barge traffic, shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 634.5 and 634.9 and designated by buoys or other approved uniform waterway markers.

40.48(2) The city of Marquette will designate and maintain the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.49(462A) Zoning of Green Island, Jackson County. All motorboats except authorized emergency vessels shall be operated at a speed no greater than 5 miles per hour year around on boat channels adjacent to the interior channel 4 levee at the Green Island State Wildlife area. Both channels begin at the Green Island county road parking lot and proceed north 7920 feet along each side of the channel 4 levee to an intersection with the Snag Slough complex.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.50(462A) Mooring of vessels on riparian property of the state of Iowa. Where the state of Iowa owns riparian property adjacent to sovereign land or water, mooring of vessels is prohibited between sunset and sunrise on those riparian or sovereign lands or waters where posted by either official buoys or official signs of the department of natural resources.

571—40.51(462A) Little River Lake, Decatur County. Motorboats of outboard or inboard-outdrive type shall be permitted on Little River Lake. Vessels operating within a designated area beginning at the dam and extending north approximately to the mouth of “Bait Shop Bay” shall be operated at a speed no greater than 5 miles per hour. The Decatur County conservation board shall designate the speed zone with marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.52(462A) Zoning of the Mississippi River, Johnson Slough, Clayton County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 627 and 629.8, in a backwater known as Johnson Slough and designated by marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.53(462A) Zoning of the Mississippi River, Mud Lake, Dubuque County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area of river mile markers 587.6 to 589.3, in a backwater known as Mud Lake and designated by marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.54(462A) Nighttime speed limit, Dickinson County. No vessels, except authorized emergency vessels, shall be operated at speeds greater than 25 miles per hour at any time between one-half hour after sunset and sunrise on all lakes located in Dickinson County.

571—40.55(462A) Zoning of Clear Lake, Cerro Gordo County.

40.55(1) Areas may be specifically designated for swimming with the use of regulatory buoys.

40.55(2) Areas within close proximity of dredging operations may be designated as areas where the speed of vessels is restricted to not greater than 5 miles per hour.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.56(462A) Zoning of Mississippi River, Des Moines County, city of Burlington. All vessels shall be operated at a speed no greater than five miles per hour within the area designated by marker buoys or other approved uniform waterway markers beginning at the north city boat ramp and public dock and extending downstream to the south city boat ramp and public dock. The zoned area shall extend no farther than 150 feet from the shore and approximately 150 feet west of the west edge of the barge channel. The city of Burlington shall designate the five-mile-per-hour speed zone with buoys approved by the natural resource commission.

[ARC 7532B, IAB 1/28/09, effective 3/6/09]

571—40.57(462A) Zoning of Catfish Creek, Mines of Spain State Recreation Area, Dubuque County. All vessels shall be operated at a speed not greater than 5 miles per hour within the area beginning at the mouth of Catfish Creek and extending upstream to the confluence of Catfish Creek and Granger Creek and designated by uniform marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.58(462A) Zoning of Lake Cornelia, Wright County. All vessels shall be operated at a speed not greater than 5 miles per hour in the boat harbor and at the boat harbor entrance within the zoned area extending 300 feet from two points on shore and 100 feet in width, equidistant from either side of the harbor entrance. The Wright County conservation board shall designate the boat harbor entrance and the public swimming area with uniform marker buoys approved by the natural resource commission.

[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.59(462A) Zoning of lakes in Dickinson County. All vessels shall be operated at a speed not greater than 5 miles per hour within 300 feet of shore on all lakes in Dickinson County.
[ARC 8877B, IAB 6/30/10, effective 8/4/10]

571—40.60(462A) Zoning of the Mississippi River, Clayton, Clayton County.

40.60(1) All vessels, except commercial barge traffic, shall be operated at a speed no greater than 5 miles per hour within an area extending 150 feet from shore and beginning at a point 1,012 feet north of Mississippi River Day Marker 624.7R and extending south to a point 1,012 feet south of the same marker (624.7R).

40.60(2) The city of Clayton shall designate and maintain the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.
[ARC 1644C, IAB 10/1/14, effective 11/5/14]

571—40.61(321G,321I,462A) Beaver Creek safety zone. A safety zone is hereby established on Beaver Creek within the property boundaries of the Camp Dodge military reservation in Polk County.

40.61(1) Watercraft and vehicles shall be prohibited from entering the safety zone in order to prevent access to areas within Camp Dodge where a hazard to the public may exist. This prohibition shall not apply to watercraft or vehicles explicitly authorized to enter the safety zone by the Iowa national guard. The safety zone boundaries shall be indicated by signage including the wording “Warning, Restricted Area, No Entrance.” The Iowa national guard shall be responsible for the acquisition, placement, and maintenance of any signage.

40.61(2) The safety zone shall be recognized by the state of Iowa only where signage is posted as required. Any section of Beaver Creek that is not designated as a safety zone shall remain open to any otherwise lawful public access.

40.61(3) Signs establishing the safety zone boundaries may be moved within the present or future boundaries of Camp Dodge at the sole discretion of Iowa national guard personnel. The Iowa national guard shall notify the department of natural resources when the location of the safety zone boundary is changed.

This rule is intended to implement Iowa Code sections 321G.2, 321I.2, 462A.3, and 462A.26.
[ARC 5053C, IAB 6/17/20, effective 7/22/20]

571—40.62(462A) Zoning of the Mississippi River, Lansing, Allamakee County.

40.62(1) All vessels, except commercial barge traffic, shall be operated at a speed not greater than 5 miles per hour within an area extending 300 feet from shore and beginning at a point 800 feet north of river mile marker 662.2 and proceeding to Lansing City Marina Dike.

40.62(2) The Friends of Pool 9 shall designate and maintain the 5-mile-per-hour speed zone with buoys approved by the natural resource commission.

This rule is intended to implement Iowa Code sections 462A.26 and 462A.32.
[ARC 5198C, IAB 10/7/20, effective 11/11/20]

These rules are intended to implement the provisions of Iowa Code sections 462A.17, 462A.26, and 462A.31.

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[◇] Two or more ARCs

BEHAVIORAL SCIENTISTS

- CHAPTER 31 LICENSURE OF MARITAL AND FAMILY THERAPISTS, MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR ANALYSTS
- CHAPTER 32 CONTINUING EDUCATION FOR MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS
- CHAPTER 33 DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS, MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR ANALYSTS

CHAPTER 31
LICENSURE OF MARITAL AND FAMILY THERAPISTS,
MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR
ANALYSTS

[Prior to 1/30/02, see 645—Chapter 30]

645—31.1(154D) Definitions. For purposes of these rules, the following definitions shall apply:

“*ACA*” means the American Counseling Association.

“*Active license*” means a license that is current and has not expired.

“*AMFTRB*” means the Association of Marriage and Family Therapy Regulatory Boards.

“*AMHCA*” means the American Mental Health Counselors Association.

“*BACB*” means the Behavior Analyst Certification Board.

“*Board*” means the board of behavioral science.

“*CCE*” means the Center for Credentialing and Education, Inc.

“*Course*” means three graduate semester credit hours.

“*Department*” means the department of public health.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a marital and family therapist, mental health counselor, behavior analyst, or assistant behavior analyst in the state of Iowa.

“*License expiration date*” means September 30 of even-numbered years for marital and family therapists and mental health counselors, and means the expiration date of the certification issued by the Behavior Analyst Certification Board for behavior analysts and assistant behavior analysts.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is or has been licensed in another state.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of marital and family therapists and mental health counselors who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“*Mental health setting*” means a behavioral health setting where an applicant is providing mental health services including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues.

“*NBCC*” means the National Board for Certified Counselors.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 645—31.16(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is currently licensed in another state which has the same or similar qualifications to those required in Iowa.

“Reinstatement” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“Temporary license” means a license to practice marital and family therapy or mental health counseling under direct supervision of a qualified supervisor as determined by the board by rule to fulfill the postgraduate supervised clinical experience requirement in accordance with this chapter.

[ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.2(154D) Requirements for permanent and temporary licensure as a mental health counselor or marriage and family therapist. The following criteria shall apply to licensure:

31.2(1) The applicant shall complete an application.

31.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

31.2(3) Each application shall be accompanied by the appropriate fees payable to the Board of Behavioral Science. The fees are nonrefundable.

31.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board of behavioral science have been received by the board or an equivalency evaluation completed by the Center for Credentialing and Education, Inc. (CCE) has been received by the board. The applicant shall present proof of meeting the educational requirements. Documentation of such proof shall be on file in the board office with the application and include one of the following:

a. For licensure as a marital and family therapist, an official transcript verifying completion of a marital and family therapy program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as defined in subrule 31.4(1) or an equivalency evaluation of the applicant’s educational credentials completed by CCE as defined in subrule 31.4(2).

b. For licensure as a mental health counselor, an official transcript verifying completion of a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) as defined in subrule 31.6(1) or an equivalency evaluation of the applicant’s educational credentials completed by CCE as defined in subrule 31.6(2).

31.2(5) The candidate for permanent licensure shall have the examination score sent directly from the testing service to the board. The candidate for temporary licensure must successfully complete the examination before the temporary license is issued.

31.2(6) The candidate for permanent licensure shall submit the required attestation of supervision forms documenting clinical experience as required in rule 645—31.5(154D) for marital and family therapy and rule 645—31.7(154D) for mental health counseling.

31.2(7) The candidate for temporary licensure for the purpose of fulfilling the postgraduate supervised clinical experience requirement must submit the Supervised Clinical Experience: Approval and Attestation form to the board and receive approval of the candidate’s supervisor(s) prior to licensure. The temporary licensee must notify the board immediately in writing of any proposed change in supervisor(s) and obtain approval of any change in supervisor(s). Within 30 days of completion of the supervised clinical experience, the attestation of the completed supervised experience must be submitted to the board office. The temporary licensee shall remain under supervision until a permanent license is issued.

31.2(8) A temporary license for the purpose of fulfilling the postgraduate supervised clinical experience requirement is valid for three years and may be renewed at the discretion of the board.

31.2(9) A licensee who was issued an initial permanent license within six months prior to the renewal shall not be required to renew the license until the renewal date two years later.

31.2(10) Submitting complete application materials. An application for a temporary or permanent license will be considered active for two years from the date the application is received. If the applicant

does not submit all materials within this time period or if the applicant does not meet the requirements for the license, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application, supporting materials, and the application fee. The board shall destroy incomplete applications after two years.

[ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5767C, IAB 7/14/21, effective 8/18/21]

645—31.3(154D) Examination requirements for mental health counselors and marital and family therapists. The following criteria shall apply to the written examination(s):

31.3(1) The applicant shall take and pass the following examinations in order to qualify for licensing:

a. For a marital and family therapist license, the Association of Marriage and Family Therapy Regulatory Board (AMFTRB) Examination in Marital and Family Therapy.

b. Prior to January 1, 2022, for a mental health counselor license or a temporary mental health counselor license, the National Counselor Examination (NCE) of the NBCC or the National Clinical Mental Health Counselor Examination (NCMHCE) of the NBCC.

c. Effective January 1, 2022, for a temporary mental health counselor license, the NCE of the NBCC or the NCMHCE of the NBCC.

d. Effective January 1, 2022, for a mental health counselor license, the NCMHCE of the NBCC.

31.3(2) Examination information will be provided when the applicant has been approved to take the examination.

31.3(3) The board will notify the applicant in writing of examination results.

31.3(4) Persons determined by the board not to have performed satisfactorily may apply for reexamination.

31.3(5) The passing score on the written examination shall be the passing point criterion established by the appropriate national testing authority at the time the test was administered.

31.3(6) An applicant who is requesting approval to take the licensure examination prior to graduation shall:

a. Apply for licensure by creating an account and paying online at ibplicense.iowa.gov.

b. Have a letter on official school letterhead sent directly from the program director to the board indicating that the applicant is in good academic standing; that the applicant will graduate from the program within three months of the date on the letter; and the applicant's anticipated date of graduation.

[ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20; ARC 5767C, IAB 7/14/21, effective 8/18/21]

645—31.4(154D) Educational qualifications for marital and family therapists. The applicant must complete the required semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.4(2); no course may be used more than once. The applicant must present proof of completion of the following educational requirements for licensure as a marital and family therapist:

31.4(1) *Accredited program.* Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.4(2) *Content-equivalent program.* Applicants must present an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy, behavioral science, or a counseling-related field from a college or university accredited by an agency recognized by the United States Department of Education, which is content-equivalent to a graduate degree in marital and family therapy. Applicants who

entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent. Graduates from non-COAMFTE-accredited marital and family therapy programs shall provide an equivalency evaluation of the graduates' educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation. In order to qualify as a "content-equivalent" degree, a graduate transcript must document:

a. At least 9 semester hours or the equivalent in each of the three areas listed below:

(1) Theoretical foundations of marital and family therapy systems. Any course which deals primarily in areas such as family life cycle; theories of family development; marriage or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).

(2) Assessment and treatment in family and marital therapy. Any course which deals primarily in areas such as family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy, such as communications, contextual, experiential, object relations, strategic, structural, systemic, transgenerational.

(3) Human development. Any course which deals primarily in areas such as human development; personality theory; human sexuality. One course must be psychopathology.

b. At least 3 semester hours or the equivalent in each of the two areas listed below:

(1) Ethics and professional studies. Any course which deals primarily in areas such as professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and interprofessional cooperation; ethical issues in marital and family counseling; and family law.

(2) Research. Any course which deals primarily in areas such as research design, methods, statistics; research in marital and family studies and therapy.

If the applicant has taught a graduate-level course as outlined above at a college or university accredited by an agency recognized by the United States Department of Education or the Council on Professional Accreditation, that course will be credited toward the course requirements.

c. A graduate-level clinical practicum in marital and family therapy of at least 300 clock hours is required for all applicants.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 2845C, IAB 12/7/16, effective 1/11/17]

645—31.5(154D) Clinical experience requirements for marital and family therapists.

31.5(1) The supervised clinical experience shall:

a. Be a minimum of two years of full-time, postgraduate supervised professional work experience in marital and family therapy.

b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.

c. Include successful completion of at least 3,000 hours of marital and family therapy that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of marital and family therapy conducted in person with couples, families and individuals.

d. Be completed in person or by electronic means.

(1) Up to 50 percent of all supervision may be completed by telephone.

(2) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.

e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.

f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of

the permanent license and must be submitted to the board upon request. The plan for supervision shall include:

- (1) The name, license number, date of licensure, address, telephone number, and email address (when available) of the supervisor;
- (2) The name, license number, address, telephone number, and email address (when available) of supervisee;
- (3) Employment setting in which experience will occur;
- (4) The nature, duration and frequency of supervision;
- (5) The number of hours of supervision per month;
- (6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;
- (7) The methodology for secure transmission of case information;
- (8) The beginning date of supervised professional practice and estimated date of completion;
- (9) The goals and objectives for the supervised professional practice; and
- (10) The signatures of the supervisor and licensee, and the dates of signatures.

g. Have only supervised clinical contact credited for this requirement.

31.5(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

- (1) Meet with the supervisor for a minimum of four hours per month;
- (2) Offer documentation of supervised hours signed by the supervisor;
- (3) Compute part-time employment on a prorated basis for the supervised professional experience;
- (4) Have the background, training, and experience that is appropriate to the functions performed;
- (5) Have supervision that is clearly distinguishable from personal psychotherapy and is contracted in order to serve professional/vocational goals;
- (6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;
- (7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and
- (8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. Effective October 1, 2020, the supervisor shall:

(1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(2) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(3) Be an Iowa-licensed social worker independent level with at least three years of clinical experience following licensure at the independent level; and

(4) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and

(5) Meet a minimum of four hours per month with the supervisee; and

(6) Provide training that is appropriate to the functions to be performed; and

(7) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(8) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.

c. Exceptions to paragraph 31.5(2)“b” shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.5(3) An applicant who has obtained American Association for Marriage and Family Therapy (AAMFT) clinical membership is considered to have met the clinical experience requirements of rule 645—31.5(154D). The applicant shall request that proof of current clinical membership be sent directly from AAMFT to the board.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5010C, IAB 3/25/20, effective 4/29/20; ARC 5795C, IAB 7/28/21, effective 6/30/21]

645—31.6(154D) Educational qualifications for mental health counselors. The applicant must complete three semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.6(2); no course may be used to fulfill more than one content area. The applicant must present proof of completion of the following educational requirements for licensure as a mental health counselor:

31.6(1) Accredited program. Applicants must present with the application an official transcript verifying completion of a master’s degree of 60 semester hours (or equivalent quarter hours) or a doctoral degree in counseling with emphasis in mental health counseling from a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2012, must present with the application an official transcript verifying completion of a master’s degree of 45 semester hours or the equivalent; or

31.6(2) Content-equivalent program. Applicants must present an official transcript verifying completion of a master’s degree or a doctoral degree from a college or university accredited by an agency recognized by the United States Department of Education which is content-equivalent to a master’s degree in counseling with emphasis in mental health counseling. Graduates from non-CACREP accredited mental health counseling programs shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation.

a. The degree of an applicant who entered a program of study prior to July 1, 2012, will be considered “content-equivalent” if the degree includes 45 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Counseling theories. Studies that provide an understanding of counseling theories, utilize personal and environmental data in the mental health counseling process, and investigate procedures that are appropriate to various counseling theories and specific settings.

(2) Supervised counseling practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student’s practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;

2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;

3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and

4. Evaluation of the student's counseling performance throughout the practicum, including documentation of a formal evaluation after the student completes the practicum.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of individuals at all developmental levels. Studies in this area include, but are not limited to, the following:

1. Theories of human development across the life span;
2. Major theories of personality development; and
3. Human behavior, including an understanding of developmental crises, disability, psychopathology, and cultural factors as they affect both normal and abnormal behavior.

(4) Social and cultural foundations. Studies that provide an understanding of issues and trends in a multicultural and diverse society. Studies in this area include, but are not limited to, the following:

1. Multicultural and pluralistic trends, including characteristics and concerns of diverse groups;
2. Attitudes and behavior based on factors such as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, gender, socioeconomic status, and intellectual ability; and
3. Individual and group interventions with diverse populations.

(5) Helping relationships. Studies that provide an understanding of counseling and consultation processes. Studies in this area include, but are not limited to, the following:

1. Helping skills and counseling and consultation theories, including coverage of relevant research and factors considered in applications;
2. Counselor or consultant characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills; and
3. Client or consultee characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, traits, capabilities, life circumstances, and developmental levels.

(6) Groups. Studies that provide an understanding of group development, dynamics, counseling theories, and group counseling methods and skills. Studies in this area include, but are not limited to, the following:

1. Principles of group dynamics, including group process components, developmental stage theories, and group members' roles and behaviors;
2. Group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;
3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature; and
4. Group counseling methods, including group counselor orientations and behaviors, ethical considerations, appropriate selection criteria and methods, and methods of evaluation of effectiveness.

(7) Career and lifestyle development. Studies that provide an understanding of career development and the interrelationships among work, family, and other life factors. Studies in this area include, but are not limited to, the following:

1. Career development theories and decision-making models;
2. Career, avocational, educational and labor market sources, print media, computer-assisted career guidance, and computer-based career information;
3. Career development program planning;
4. Interrelationships among work, family, and other life factors such as multicultural and gender issues, as related to career development;

5. Career and educational placement, follow-up and evaluation; and
 6. Assessment instruments relevant to career planning and decision making.
- (8) Diagnosis and assessment treatment procedures. Studies that provide an understanding of individual and group approaches to assessment and evaluation. Studies in this area include, but are not limited to, the following:
1. Theoretical and historical bases for assessment techniques and methods of interpretation of appraisal data and information;
 2. Types of educational and psychological appraisal as appropriate to the helping process;
 3. Validity, including evidence for establishing content, construct, and empirical validity;
 4. Reliability, including methods of establishing stability and internal and equivalence reliability;
 5. Major appraisal methods, including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
 6. Psychometric statistics, including types of test scores, measures of central tendency, indices of variability, standard errors and correlations; and
 7. Gender, ethnicity, language, disability, and cultural factors related to the assessment and evaluation of individuals and groups.
- (9) Research and program evaluation. Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research. Studies in this area include, but are not limited to, the following:
1. Basic types of research methods, including qualitative, quantitative-descriptive, and quantitative-descriptive-experimental designs;
 2. Basic statistics, including both univariate and bivariate hypothesis testing;
 3. Uses of computers for data management and analyses; and
 4. Ethical and legal considerations in research.
- (10) Professional orientation. Studies that provide an understanding of all aspects of professional functioning, including history, roles, organizational structures, ethics, standards, and credentialing. Studies in this area include, but are not limited to, the following:
1. History of the helping professions, including significant factors and events;
 2. Professional roles and functions, including similarities with and differences from other types of professionals;
 3. Professional organizations (primarily ACA or AMHCA, their divisions, and their branches), including membership benefits, activities, services to members, and current emphases;
 4. Ethical standards of the ACA or AMHCA and the evolution of those standards, legal issues, and applications to various professional activities (e.g., appraisal and group work);
 5. Professional preparation standards and their evolution and current applications; and
 6. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues.
- (11) Supervised counseling internship that provides an opportunity for the trainee to perform under supervision a variety of activities that a regularly employed staff member in a setting would be expected to perform. A regularly employed staff member is defined as a person occupying the professional role to which the trainee is aspiring. The internship follows a supervised practicum experience. A three-semester-hour internship includes the following:
1. A minimum of 120 hours of direct service with clientele appropriate to the program of study;
 2. A minimum of 1 hour per week of individual supervision, throughout the internship, usually performed by the on-site supervisor; and
 3. A minimum of 1½ hours per week of group supervision, throughout the internship, usually performed by a program faculty member supervisor.
- (12) Psychopathology. Studies that provide an understanding of the description, classification and diagnosis of behavior disorders and dysfunction. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;
2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;
3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;
4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and
5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

b. The degree of an applicant who entered a program of study on or after July 1, 2012, will be considered “content-equivalent” if the degree includes 60 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Professional orientation and ethical practice. Studies that provide an understanding of all of the following aspects of professional functioning:

1. History and philosophy of the counseling profession, including mental health counseling;
2. Professional roles, functions, and relationships of the mental health counselor with other human services providers, including strategies for interagency/interorganization collaboration and communication;
3. Counselors’ roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event;
4. Self-care strategies appropriate to the counselor role;
5. Counseling supervision models, practices, and processes;
6. Professional organizations (primarily ACA or AMHCA, and their divisions, branches, and affiliates), including membership benefits, activities, services to members, and current emphases;
7. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;
8. The role and process of the professional mental health counselor advocating on behalf of the profession;
9. Advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and
10. Ethical standards of ACA or AMHCA and related entities, and applications of ethical and legal considerations in professional counseling.

(2) Social and cultural diversity. Studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural and diverse society including all of the following:

1. Multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;
2. Attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students’ understanding of self and culturally diverse clients;
3. Theories of multicultural counseling, identity development, and social justice;
4. Individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;
5. Counselors’ roles in developing cultural self-awareness, promoting cultural social justice, advocacy, and conflict resolution and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind or body; and

6. Counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, including all of the following:

1. Theories of individual and family development and transitions across the life span;
2. Theories of learning and personality development including current understandings about neurobiological behavior;
3. Effects of crises, disasters, and other trauma-causing events on persons of all ages;
4. Theories and models of individual, cultural, couple, family, and community resilience;
5. A general framework for understanding exceptional abilities and strategies for differentiated interventions;
6. Human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;
7. Theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment; and
8. Strategies for facilitating optimum development over the life span.

(4) Career development. Studies that provide an understanding of career development and related life factors, including all of the following:

1. Career development theories and decision-making models;
2. Career, avocational, educational, occupational and labor market information resources and career information systems;
3. Career development program planning, organization, implementation, administration, and evaluation;
4. Interrelationships among and between work, family, and other life roles and factors including the role of multicultural issues in career development;
5. Career and educational planning, placement, follow-up, and evaluation;
6. Assessment instruments and techniques relevant to career planning and decision making; and
7. Career counseling processes, techniques, and resources, including those applicable to specific populations.

(5) Helping relationships. Studies that provide an understanding of counseling processes in a multicultural society, including all of the following:

1. An orientation to wellness and prevention as desired counseling goals;
2. Counselor characteristics and behaviors that influence helping processes;
3. An understanding of essential interviewing and counseling skills;
4. Counseling theories that provide the student with a model(s) to conceptualize client presentation and select appropriate counseling interventions. Students shall be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;
5. A systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions;
6. A general framework for understanding and practicing consultation; and
7. Crisis intervention and suicide prevention models, including the use of psychological first-aid strategies.

(6) Group work. Studies that provide both theoretical and experiential understanding of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society, including all of the following:

1. Principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;
2. Group leadership or facilitation styles and approaches, including characteristics of various types of group leaders and leadership styles;

3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;

4. Group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness; and

5. Experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term.

(7) Assessment. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society, including the following:

1. Historical perspectives concerning the nature and meaning of assessment;

2. Basic concepts of standardized and nonstandardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, and behavioral observations;

3. Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;

4. Reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);

5. Validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);

6. Social and cultural factors related to the assessment and evaluation of individuals, groups, and specific populations;

7. Ethical strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling; and

8. An understanding of general principles and methods of case conceptualization, assessment, or diagnoses of mental and emotional status.

(8) Research and program evaluation. Studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

1. The importance of research in advancing the counseling profession;

2. Research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;

3. Statistical methods used in conducting research and program evaluation;

4. Principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;

5. Use of research to inform evidence-based practice; and

6. Ethical and culturally relevant strategies for interpreting and reporting the results of research and program evaluation studies.

(9) Diagnosis and treatment planning. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society. Studies in this area include, but are not limited to, the following:

1. The principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual;

2. The established diagnostic criteria for mental or emotional disorders that describe treatment modalities and placement criteria within the continuum of care;

3. The impact of co-occurring substance use disorders on medical and psychological disorders;

4. The relevance and potential biases of commonly used diagnostic tools as related to multicultural populations;

5. The appropriate use of diagnostic tools, including the current edition of the Diagnostic and Statistical Manual, to describe the symptoms and clinical presentation of clients with mental or emotional impairments;

6. The ability to conceptualize accurate multi-axial diagnoses of disorders presented by clients and discuss the differential diagnosis with collaborating professionals; and

7. The ability to differentiate between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events.

(10) Psychopathology. Studies that provide an understanding of emotional and mental disorders experienced by persons of all ages, characteristics of disorders, and common nosologies of emotional and mental disorders utilized within the U.S. health care system for diagnosis and treatment planning. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;
2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;
3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;
4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and
5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

(11) Practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;
2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;
3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and
4. Evaluation of the student's counseling performance throughout the practicum including documentation of a formal evaluation after the student completes the practicum.

(12) Internship. A graduate-level clinical supervised counseling internship in a mental health setting that requires students to complete a supervised internship of 600 clock hours that is begun after the student's successful completion of the practicum. The internship is intended to reflect the comprehensive work experience of a professional counselor appropriate to clinical mental health counseling. The internship provides an opportunity for the student to perform, under supervision, a variety of counseling activities that a mental health counselor is expected to perform. The student's internship includes all of the following:

1. At least 240 hours of direct service with clientele, including experience leading groups;
2. Weekly interaction that averages 1 hour per week of individual supervision or triadic supervision throughout the internship, usually performed by the on-site supervisor;
3. An average of 1½ hours per week of group supervision, provided on a regular schedule throughout the internship, usually performed by a program faculty member supervisor;
4. The opportunity for the student to become familiar with a variety of professional activities in addition to direct service (e.g., record keeping, supervision, information and referral, in-service and staff meetings);
5. The opportunity for the student to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the student's interactions with clients;
6. The opportunity for the student to gain supervised experience in the use of a variety of professional resources such as assessment instruments, technologies, print and nonprint media, professional literature, and research; and

7. Evaluation of the student's counseling performance throughout the internship including documentation of a formal evaluation by a program faculty member in consultation with the site supervisor after the student completes the internship.

31.6(3) Foreign-trained marital and family therapists or mental health counselors. Foreign-trained marital and family therapists or mental health counselors shall:

a. Provide an equivalency evaluation of their educational credentials by the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone (310)258-9451; website www.ierf.org or email at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a mental health counselor program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.
[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.7(154D) Clinical experience requirements for mental health counselors.

31.7(1) The supervised clinical experience shall:

a. Be a minimum of two years of postgraduate supervised professional work experience in mental health counseling.

b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.

c. Include successful completion of at least 3,000 hours of mental health counseling that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of mental health counseling conducted in person with couples, families and individuals.

d. Be completed in person or by electronic means.

(1) Up to 50 percent of all supervision may be completed by telephone.

(2) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.

e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.

f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of the permanent license and must be submitted to the board upon request. The plan for supervision shall include:

(1) The name, license number, date of licensure, address, telephone number, and email address (when available) of the supervisor;

(2) The name, license number, address, telephone number, and email address (when available) of supervisee;

(3) Employment setting in which experience will occur;

(4) The nature, duration and frequency of supervision;

(5) The number of hours of supervision per month;

(6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;

(7) The methodology for secure transmission of case information;

(8) The beginning date of supervised professional practice and estimated date of completion;

(9) The goals and objectives for the supervised professional practice; and

(10) The signatures of the supervisor and licensee, and the dates of signatures.

g. Have only supervised clinical contact credited for this requirement.

31.7(2) To meet the requirements of the supervised clinical experience:

- a.* The supervisee must:
- (1) Meet with the supervisor a minimum of four hours per month;
 - (2) Offer documentation of supervised hours signed by the supervisor;
 - (3) Compute part-time employment on a prorated basis for the supervised professional experience;
 - (4) Have the background, training, and experience that are appropriate to the functions performed;
 - (5) Have supervision that is clearly distinguishable from personal counseling and is contracted in order to serve professional/vocational goals;
 - (6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;
 - (7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and
 - (8) Not participate in the following activities which are deemed unacceptable for clinical supervision:
 1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.
 2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.
 3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.
 4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.
 5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.
- b.* Effective October 1, 2020, the supervisor shall:
- (1) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or
 - (2) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or
 - (3) Be an Iowa-licensed social worker independent level with at least three years of clinical experience following licensure at the independent level; and
 - (4) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and
 - (5) Meet a minimum of four hours per month with the supervisee; and
 - (6) Provide training that is appropriate to the functions to be performed; and
 - (7) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and
 - (8) Not supervise any mental health counselor or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.
- c.* Exceptions to paragraph 31.7(2)“*b*” shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.7(3) Rescinded IAB 7/6/05, effective 8/10/05.

31.7(4) An applicant who has obtained Certified Clinical Mental Health Counselor status with the National Board for Certified Counselors (NBCC) is considered to have met the clinical experience requirements of rule 645—31.7(154D). The applicant shall ensure that proof of current certified clinical mental health counselor status be sent directly from NBCC to the board.
[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5010C, IAB 3/25/20, effective 4/29/20; ARC 5795C, IAB 7/28/21, effective 6/30/21]

645—31.8(154D) Licensure by endorsement for mental health counselors and marital and family therapists. An applicant who has been a licensed marriage and family therapist or mental health

counselor under the laws of another jurisdiction may file an application for licensure by endorsement with the board office.

31.8(1) The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

- a. Submits to the board a completed application;
- b. Pays the licensure fee;
- c. Shows evidence of licensure requirements that are similar to those required in Iowa;
- d. Provides official transcripts sent directly from the school to the board verifying completion of a master's degree of 45 hours or equivalent if the applicant entered a program of study prior to July 1, 2012, or verifying completion of a master's degree of 60 hours or equivalent if the applicant entered a program of study on or after July 1, 2012, or the appropriate doctoral degree. Graduates from a non-CACREP-accredited mental health counselor program or a non-COAMFTE-accredited marital and family therapy program shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation;
- e. Supplies satisfactory evidence of the candidate's qualifications in writing on the prescribed forms by the candidate's supervisors. If verification of clinical experience is not available, the board may consider submission of documentation from the state in which the applicant is currently licensed or equivalent documentation of supervision;
- f. Provides verification(s) of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- (1) Licensee's name;
- (2) Date of initial licensure;
- (3) Current licensure status; and
- (4) Any disciplinary action taken against the license; and

g. Has the examination score sent directly from the testing service to the board.

31.8(2) In lieu of meeting the requirements of paragraphs 31.8(1) "d" and "e," applicants who meet the qualifications below may instead submit documentation demonstrating how each of the qualifications below is satisfied:

- a. The applicant has been licensed as a mental health counselor or a marital and family therapist in another state for at least five years at the independent level (independent level means the highest level of licensure in the field offered by the particular state);
- b. The applicant has been practicing under the independent license in a clinical mental health or marital and family therapy counseling setting for at least five years;
- c. The applicant possesses a master's degree or higher in mental health counseling or marital and family therapy or an equivalent counseling-related field; and
- d. The applicant does not have any past or pending disciplinary action from any state licensing boards related to any mental health counseling or marital and family therapy license currently or previously held by the applicant.

31.8(3) A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5767C, IAB 7/14/21, effective 8/18/21]

645—31.9(147) Licensure of behavior analysts and assistant behavior analysts.

31.9(1) The applicant shall complete an application.

31.9(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

31.9(3) Each application shall be accompanied by the appropriate fees payable to the board of behavioral science. The fees are nonrefundable.

31.9(4) For licensure as a behavior analyst, the applicant shall submit proof of current BACB certification as a board-certified behavior analyst or board-certified behavior analyst-doctoral. For licensure as an assistant behavior analyst, the applicant shall submit proof of current BACB certification as a board-certified assistant behavior analyst.

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5767C, IAB 7/14/21, effective 8/18/21]

645—31.10(147) License renewal for mental health counselors and marriage and family therapists.

31.10(1) The biennial license renewal period for a license to practice marital and family therapy or mental health counseling shall begin on October 1 of an even-numbered year and end on September 30 of the next even-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.10(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

31.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—32.2(272C). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

31.10(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting as required by Iowa Code section 232.69(3)"*b*" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "*d*."

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5)"*b*" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "*d*."

c. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs "*a*" and "*b*," including program date(s), content, duration, and proof of participation.

d. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

e. The board may select licensees for audit of compliance with the requirements in paragraphs "*a*" to "*d*."

31.10(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

31.10(6) A person licensed to practice as a marital and family therapist or mental health counselor shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

31.10(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 5.3(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice mental health counseling or marital and family therapy in Iowa until the license is reactivated. A licensee who practices mental health counseling or marital and family therapy in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.11(272C) Initial licensing, reactivation, and license renewal for behavior analysts and assistant behavior analysts.

31.11(1) An initial license for a behavior analyst or assistant behavior analyst shall be issued with the same expiration date as the applicant's current certification issued by BACB.

31.11(2) The biennial license renewal period for a behavior analyst or assistant behavior analyst shall run concurrent with the licensee's BACB certification. Each license renewed shall be given the expiration date that is on the licensee's current BACB certification. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.11(3) A licensee seeking renewal shall:

- a. Meet the continuing education requirements required by BACB to renew a certification.
- b. Maintain current certification as a board-certified behavior analyst, board-certified behavior analyst-doctoral, or board-certified assistant behavior analyst issued by BACB.
- c. Submit the completed renewal application and renewal fee before the license expiration date.

31.11(4) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

31.11(5) A person licensed as a behavior analyst or assistant behavior analyst shall keep the person's license certificate and renewal displayed in a conspicuous public place at the primary site of practice.

31.11(6) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the renewal. The licensee shall be assessed a late fee as specified in 645—subrule 5.3(5). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.11(7) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not engage in the practice of applied behavior analysis for which a license is required in Iowa until the license is reactivated. A licensee who practices applied behavior analysis in a capacity that requires licensure in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

31.11(8) Reactivation. To apply for reactivation of an inactive license, a licensee shall submit a completed renewal application and proof of current certification and shall be assessed a reactivation fee as specified in 645—subrule 5.3(6).

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5767C, IAB 7/14/21, effective 8/18/21]

645—31.12(147) Licensee record keeping.

31.12(1) A licensee shall maintain sufficient, timely, and accurate documentation in client records.

31.12(2) For purposes of this rule, “client” means the individual, couple, family, or group to whom a licensee provides direct clinical services.

31.12(3) A licensee’s records shall reflect the services provided, facilitate the delivery of services, and ensure continuity of services in the future.

31.12(4) Clinical services. A licensee who provides clinical services in any employment setting, including private practice, shall:

a. Store records in accordance with state and federal statutes and regulations governing record retention and with the guidelines of the licensee’s employer or agency, if applicable. If no other legal provisions govern record retention, a licensee shall store all client records for a minimum of seven years after the date of the client’s discharge or death, or, in the case of a minor, for three years after the client reaches the age of majority under state law or seven years after the date of the client’s discharge or death, whichever is longer.

b. Maintain timely records that include subjective and objective data, an assessment, a treatment plan, and any revisions to the assessment or plan made during the course of treatment.

c. Provide the client with reasonable access to records concerning the client. A licensee who is concerned that a client’s access to the client’s records could cause serious misunderstanding or harm to the client shall provide assistance in interpreting the records and consultation with the client regarding the records. A licensee may limit a client’s access to the client’s records, or portions of the records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both the client’s request for access and the licensee’s rationale for withholding some or all of a record shall be documented in the client’s records.

d. Take steps to protect the confidentiality of other individuals identified or discussed in any records to which a client is provided access.

31.12(5) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, the licensee shall ensure that a duplicate hard-copy record or a backup, unalterable electronic record is maintained.

31.12(6) Correction of records.

a. Hard-copy records. Original notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the original record, it must be crossed out with a single, nondeleting line and be initialed and dated by the licensee.

b. Electronic records. If a record is stored in an electronic format, the record may be amended with a signed addendum attached to the record.

31.12(7) Confidentiality and transfer of records. Marital and family therapists or mental health counselors shall preserve the confidentiality of client records in accordance with their respective rules of conduct and with federal and state law. Upon receipt of a written release or authorization signed by the client, the licensee shall furnish such therapy records, or copies of the records, as will be beneficial for the future treatment of that client. A fee may be charged for duplication of records, but a licensee may not refuse to transfer records for nonpayment of any fees. A written request may be required before transferring the record(s).

31.12(8) Retirement, death or discontinuance of practice.

a. If a licensee is retiring or discontinuing practice and is the owner of a practice, the licensee shall notify in writing all active clients and, upon knowledge and agreement of the clients, shall make reasonable arrangements with those clients to transfer client records, or copies of those records, to the succeeding licensee.

b. Upon a licensee’s death:

(1) The licensee’s employer or representative must ensure that all client records are transferred to another licensee or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The licensee's employer or representative shall notify each active client that the client's records will be transferred to another licensee or entity that will retain custody of the records and that, at the client's written request, the records will be sent to the licensee or entity of the client's choice.

31.12(9) Nothing stated in this rule shall prohibit a licensee from conveying or transferring the licensee's client records to another licensed individual who is assuming a practice, provided that written notice is furnished to all clients.

645—31.13 to 31.15 Reserved.

645—31.16(17A,147,272C) License reactivation for mental health counselors and marital and family therapists. To apply for reactivation of an inactive license, a licensee shall:

31.16(1) Submit a reactivation application on a form provided by the board.

31.16(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

31.16(3) Provide verification of current competence to practice mental health counseling or marital and family therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 40 hours of continuing education obtained within the two years immediately preceding the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 80 hours of continuing education obtained within the two years immediately preceding the application for reactivation.

[ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.17(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—31.16(17A,147,272C) or subrule 31.11(8) prior to practicing mental health counseling, marital and family therapy, or applied behavior analysis in this state.

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.18(154D) Marital and family therapy and mental health counselor services subject to regulation. Marital and family therapy and mental health counselor services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the marital and

family therapy and mental health counselor, shall constitute the practice of marital and family therapy and mental health counseling and shall be subject to regulation in Iowa.

645—31.19(154D) Temporary licensees. A temporary licensee shall engage only in the practice of marital and family therapy or mental health counseling as part of an agency or group practice with oversight over the temporary licensee. The agency or group practice shall have at least one independently licensed mental health provider. A temporary licensee shall not practice as a solo practitioner or solely with other temporary licensees.

[ARC 5010C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code chapters 17A, 147, 154D and 272C.

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[◇] Two or more ARCs

¹ February 18, 2009, effective date of amendments to 645—31.4(154D) to 645—31.8(154D), **ARC 7476B**, Items 5 to 9, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 6, 2009.

SOCIAL WORKERS

CHAPTER 280	LICENSURE OF SOCIAL WORKERS
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CHAPTER 280
LICENSURE OF SOCIAL WORKERS

645—280.1(154C) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“ASWB” means the Association of Social Work Boards.

“Board” means the board of social work.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“LBSW” means licensed bachelor social worker.

“Licensee” means any person licensed to practice as a social worker in the state of Iowa.

“License expiration date” means December 31 of even-numbered years.

“Licensure by endorsement” means the issuance of an Iowa license to practice social work to an applicant who is or has been licensed in another state.

“LISW” means licensed independent social worker.

“LMSW” means licensed master social worker.

“Mandatory training” means training on identifying and reporting child abuse or dependent adult abuse required of social workers who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“Reactivate” or *“reactivation”* means the process as outlined in rule 645—280.14(17A,147,272C) by which an inactive license is restored to active status.

“Reciprocal license” means the issuance of an Iowa license to practice social work to an applicant who is currently licensed in another state and that state’s board of examiners has a mutual written agreement with the Iowa board of social work to license persons who have the same or similar qualifications to those required in Iowa.

“Reinstatement” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.2(154C) Social work services subject to regulation. Social work services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the social worker, shall constitute the practice of social work and shall be subject to regulation in Iowa.

645—280.3(154C) Requirements for licensure. The following criteria shall apply to licensure:

280.3(1) The applicant shall submit a completed licensure application.

280.3(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

280.3(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Social Work. The fees are nonrefundable.

280.3(4) No application shall be considered by the board until official copies of academic transcripts have been received by the board except as provided in 280.4(6).

280.3(5) The applicant shall provide verification of license(s) from every state in which the applicant has been licensed as a social worker, sent directly from the state(s) to the Iowa board of social work office.

280.3(6) The candidate shall take the examination(s) required by the board pursuant to these rules.

280.3(7) An applicant for a license as an independent social worker shall have met the requirements for supervision pursuant to 645—280.6(154C).

280.3(8) Each social worker who seeks to attain licensure as an independent social worker shall have been granted a master's or doctoral degree in social work and practiced at that level.

280.3(9) Notification of licensure shall be sent to the licensee.

280.3(10) Licensees who were issued their initial licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal date two years later.

280.3(11) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

280.3(12) In lieu of the requirements in subrules 280.3(4) and 280.3(5), the board will accept the ASWB Social Work Registry verification of academic transcripts and verification of licensure in other states.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 3744C, IAB 4/11/18, effective 5/16/18; ARC 5771C, IAB 7/14/21, effective 8/18/21]

645—280.4(154C) Written examination.

280.4(1) The applicant is required to take and pass the ASWB examination at the appropriate level as follows:

a. Bachelor level social worker—the basic level examination.

b. Master level social worker—the intermediate level examination.

c. Independent level social worker—the clinical level examination.

280.4(2) The electronic examination shall be scheduled with ASWB.

280.4(3) Application for any required examination will be denied or deferred by the board if the applicant lacks the required education or practice experience.

280.4(4) The applicant and the board shall be notified of the ASWB examination results, and the applicant may receive the results at the time of the examination. The board will accept only official results from the ASWB examination service that are sent directly from the examination service to the board.

280.4(5) The ASWB passing score will be utilized as the Iowa passing score.

280.4(6) An applicant may sit for the examination if the applicant meets the requirements stated in 645—280.3(154C). Upon written request of the applicant, the board may authorize a student to sit for the examination prior to the receipt of the official transcript if the student is in the last semester of an approved master of social work program. The student shall submit an application for licensure at the master's level and the fee, and, in lieu of a transcript, the student shall request that the school submit a letter directly to the board office. The letter shall state that the student is currently enrolled in a master of social work program and the student's expected date of graduation. Upon completion of degree requirements, the applicant shall have the transcript showing the date of the degree sent directly from the school to the board office at the Board of Social Work, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

280.4(7) In lieu of the requirements in subrule 280.4(4), the board will accept the ASWB Social Work Registry verification of the ASWB examination results.

[ARC 8371B, IAB 12/16/09, effective 1/20/10]

645—280.5(154C) Educational qualifications.

280.5(1) Bachelor level social worker. An applicant for a license as a bachelor level social worker shall present evidence satisfactory to the board that the applicant possesses a bachelor's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation.

280.5(2) Master level social worker. An applicant for a license as a master level social worker shall present evidence satisfactory to the board that the applicant:

- a. Possesses a master's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation; or
- b. Possesses a doctoral degree in social work from a college or university approved by the board at the time of graduation.

280.5(3) Independent level social worker. An applicant for a license as an independent level social worker shall present evidence satisfactory to the board that the applicant:

- a. Possesses a master's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation; or
- b. Possesses a doctoral degree in social work from a college or university approved by the board at the time of graduation.

280.5(4) Foreign-trained social workers shall:

a. Provide an equivalency evaluation of their educational credentials by International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, California 90231-3665, telephone (310)258-9451, website www.ierf.org or email at info@ierf.org; or obtain a certificate of equivalency from the Council on Social Work Education, 1701 Duke Street, Suite 200, Alexandria, Virginia 22314-3457, telephone (703)683-8080, website www.cswe.org. The professional curriculum must be equivalent to that stated in these rules. The candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a social work program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

[ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.6(154C) Period of supervised professional practice for LISW. To qualify for licensure at the independent level, an LMSW shall complete a period of supervised professional practice in accordance with the requirements of this rule.

280.6(1) *Minimum requirements.* The period of supervised professional practice shall:

- a. Not begin prior to licensure at the master's level.
- b. Have a duration of at least two calendar years.
- c. Consist of a minimum of 4,000 hours of social work practice at the master's level.
- d. Include at least 110 hours of direct supervision equitably distributed throughout the period and in compliance with the requirements of subrule 280.6(3).
- e. Be done pursuant to one or more written supervision plans that comply with the requirements of subrule 280.6(7).

280.6(2) *Content of supervised professional practice.* The supervisor shall ensure that the period of supervised professional practice includes the following:

- a. Psychosocial assessments, including evaluation of symptoms and behaviors and the effects of the environment on behavior;
- b. Diagnostic practice using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association;
- c. Treatment, including the establishment of treatment goals, psychosocial therapy, and differential treatment planning;
- d. Practice management skills;
- e. Skills required for continued competence;
- f. Training on ethical standards and legal and regulatory requirements; and

g. Development of professional identity.

280.6(3) Direct supervision. The required 110 hours of direct supervision may be obtained through individual meetings between the supervisor and supervisee or through group supervision meetings consisting of the supervisor and more than one supervisee.

a. Supervision may occur through in-person meetings or through electronic meetings using an interactive real-time system that provides for visual and audio interaction between the supervisor and supervisee.

b. A maximum of 60 hours of direct supervision may be obtained through group supervision meetings. A maximum of six supervisees may participate in any group supervision meeting.

280.6(4) Supervisor eligibility requirements.

a. To be eligible to serve as a supervisor for the period of supervised professional practice, a supervisor shall:

(1) Hold an active Iowa license to practice social work at the independent level, an active Iowa license to practice mental health counseling without supervision, or an active Iowa license to practice marital and family therapy without supervision in Iowa. If the supervised professional practice occurs in another state, a supervisor licensed in that state may serve as a supervisor and may provide direct supervision hours if the supervisor holds an equivalent license.

(2) Have at least three years of social work practice at the independent level, which must include a minimum of 4,000 hours of practice.

(3) Complete a six-hour continuing education course pertaining to social work practice supervision or one master's level course in supervision.

b. Any request for a supervisor who does not meet these requirements must be submitted to the board for approval before supervision begins. The board will only approve an otherwise ineligible supervisor if the supervisee demonstrates that eligible supervisors are unavailable or unwilling to provide supervision. Any practice or supervision hours obtained under an ineligible supervisor prior to board approval cannot be counted toward completion of the period of supervised professional practice.

280.6(5) Supervisor responsibilities. A supervisor shall provide adequate supervision to all supervisees. Failure to provide adequate supervision may be grounds for disciplinary action. A supervisor shall be responsible for:

- a. Timely submission of the supervision plan;
- b. Providing supervision in accordance with this rule;
- c. Directing the supervisee to obtain written releases of information from patients when legally required for purposes of providing supervision;
- d. Providing periodic evaluations and feedback regarding the supervisee's performance to the supervisee;
- e. Answering questions and assisting supervisees as new or difficult issues arise;
- f. Ensuring the supervisee's caseload is manageable;
- g. Reporting to the board any violations of board rules by supervisees; and
- h. Completing a supervision report.

280.6(6) Supervisee responsibilities. A supervisee shall comply with all statutes and rules governing the practice of social work. A supervisee shall be responsible for:

- a. Timely submission of the supervision plan;
- b. Obtaining supervision in accordance with this rule;
- c. Obtaining written releases of information from patients when legally required for purposes of receiving supervision;
- d. Asking the supervisor to provide periodic evaluations and feedback regarding the supervisee's performance;
- e. Asking questions of the supervisor when assistance is needed or when new or difficult issues arise;
- f. Reporting any issues related to caseload, including volume and difficulty, to the supervisor;
- g. Reporting to the board any violations of board rules by the supervisor; and

h. Maintaining a copy of every supervision plan and supervision report until such time as the supervisee is issued a license to practice social work at the independent level.

280.6(7) *Supervision plan.* A current written supervision plan must be maintained throughout the period of supervised professional practice. Each supervisor who provides practice supervision or direct supervision hours shall be named on a supervision plan.

a. A written supervision plan must be established and submitted to the board before the period of supervised professional practice begins. The board will perform an initial review of each supervision plan and notify the supervisee of approval or denial of the plan within 45 days of receipt. A supervisee may begin supervised professional practice after submission of the supervision plan but cannot count any practice or supervision hours obtained pursuant to a supervision plan that is ultimately denied by the board.

b. If a supervisee is changing supervisors or adding an additional supervisor, a revised supervision plan shall be submitted to the board for approval at the time of the change or addition. A supervisee may continue supervised professional practice after submission of a revised supervision plan but cannot count any practice or supervision hours obtained pursuant to a revised supervision plan that is ultimately denied by the board.

c. The board maintains a supervision plan form that may be utilized to write the supervision plan. A supervision plan shall include:

- (1) The name, license number, date of licensure, address, telephone number, and email address of the supervisor;
- (2) The name, license number, address, telephone number, and email address of the supervisee;
- (3) The name of the agency, institution, or organization providing the period of supervised professional practice;
- (4) The start date and estimated date of completion of the period of supervised professional practice;
- (5) The goals and objectives for the period of supervised professional practice;
- (6) The nature, duration, and frequency of direct supervision, including the number of hours of direct supervision per week, the schedule for in-person and electronic supervision meetings, and the use of group supervision; and
- (7) The signatures of the supervisor and supervisee, and the dates of the signatures.

280.6(8) *Completion of supervised professional practice.*

a. At the conclusion of the period of supervised professional practice, the supervisee shall have any and all supervisors complete a supervision report on the form provided by the board. Each supervision report must be signed and dated by the supervisor and supervisee.

b. The board will review each supervision report for approval of the hours pertaining to the particular report. The board may deny any practice or supervision hours that were not obtained in compliance with this rule. The board may deny any practice or supervision hours if the supervisor indicates that the supervisee did not adhere to the ethical standards and legal and regulatory requirements governing the practice of social work or if the supervisor does not recommend the supervisee for licensure at the independent level.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 8586B, IAB 3/10/10, effective 4/14/10; ARC 0093C, IAB 4/18/12, effective 5/23/12; ARC 3744C, IAB 4/11/18, effective 5/16/18; ARC 5795C, IAB 7/28/21, effective 6/30/21]

645—280.7(154C) Licensure by endorsement.

280.7(1) An applicant who has been a licensed social worker under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia, another state, territory, province or foreign country who:

- a.* Submits to the board a completed application;
- b.* Pays the licensure fee;
- c.* Shows evidence of licensure requirements that are similar to those required in Iowa;
- d.* Provides official copies of the academic transcripts;

e. Provides official copies of the appropriate or higher level examination score sent directly from the ASWB; and

f. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- (1) Licensee's name;
- (2) Date of initial licensure;
- (3) Current licensure status; and
- (4) Any disciplinary action taken against the license.

280.7(2) A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).

In lieu of the requirements in paragraphs 280.7(1) "*d*," "*e*," and "*f*," the board will accept the ASWB Social Work Registry verification of academic transcripts, examination scores, and licensure in other states.

[ARC 0093C, IAB 4/18/12, effective 5/23/12; ARC 5771C, IAB 7/14/21, effective 8/18/21]

645—280.8 Reserved.

645—280.9(154C) License renewal.

280.9(1) The biennial license renewal period for a license to practice social work shall begin on January 1 of odd-numbered years and end on December 31 of the next even-numbered year. Every licensee shall renew on a biennial basis. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of the responsibility for renewing the license.

280.9(2) Renewal procedures.

a. A licensee seeking renewal shall:

(1) Meet the continuing education requirements of rule 645—281.2(154C,272C) and the mandatory reporting requirements of subrule 280.9(3). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

(2) Submit the completed renewal application and renewal fee before the license expiration date.

b. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

c. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 27 hours of continuing education per biennium for each subsequent license renewal.

d. Persons licensed to practice social work shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

e. Failure to receive the notice of renewal shall not relieve the licensee of the responsibility for submitting the required materials and the renewal fee to the board office 30 days before license expiration.

f. A social worker whose Iowa license is inactive, delinquent, closed, retired, voluntarily surrendered, suspended, or revoked cannot advance to a higher level until the license is again active.

280.9(3) Mandatory reporting of child abuse and dependent adult abuse.

a. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats children in Iowa shall complete an initial two-hour child abuse mandatory reporter training course offered by the department of human services within six months of employment, or prior to the expiration of a current certificate. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certificate.

b. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats adults in Iowa shall complete an initial two-hour dependent adult abuse mandatory reporter training course offered by the department of human services within six months of employment, or prior to the expiration of a current certificate. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certificate.

c. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including waiver of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 281.

d. The board may select licensees for audit of compliance with the requirements in paragraphs “*a*” and “*b*.”

280.9(4) Late renewal. To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

280.9(5) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a social worker in Iowa until the license is reactivated. A licensee who practices as a social worker in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

280.9(6) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

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645—280.10 to 280.13 Reserved.

645—280.14(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

280.14(1) Submit a reactivation application on a form provided by the board.

280.14(2) Pay the reactivation fee that is due as specified in 645—subrule 5.19(4).

280.14(3) Provide verification of current competence to practice social work by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 27 hours of continuing education within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the verifications in both subparagraphs (1) and (2) below plus the verification in either subparagraphs (3) or (4) below.

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 27 hours of continuing education within two years of application for reactivation; and

(3) Verification of passing the ASWB examination within the last five years at the appropriate or higher level as follows:

1. Bachelor level social worker – the bachelor's level examination; or
2. Master level social worker – the master's level examination; or
3. Independent level social worker – the clinical level examination; or

(4) Verification of continued social work practice at the appropriate or higher level in another state for a minimum of two years immediately preceding the application for reactivation.

[ARC 0093C, IAB 4/18/12, effective 5/23/12; ARC 5771C, IAB 7/14/21, effective 8/18/21]

645—280.15(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—280.14(17A,147,272C) prior to practicing social work in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 154C and 272C.

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⁰ Two or more ARCs

¹ Effective date of rules 161.212 to 161.217 delayed 70 days by the Administrative Rules Review Committee.

² Effective date of 280.100(154C) is July 1, 1993.

³ Effective date of **ARC 9102A** delayed 70 days by the Administrative Rules Review Committee at its meeting held July 13, 1999; delay lifted at the meeting held August 3, 1999, effective August 4, 1999.

REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, chapter 1245.

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[Prior to 12/17/86, Revenue Department[730]]

701—18.1(422,423) Tangible personal property purchased from the United States government. Tangible personal property purchased from the United States government or any of the governmental agencies shall be exempt from sales tax, but such purchases shall be taxable to the purchaser under the provisions of the use tax law. Persons making purchases from the United States government, unless exempt from the provisions of Iowa Code section 422.44, shall report and pay use tax at the current rate on the purchase price of such purchases.

This rule is intended to implement Iowa Code sections 422.44 and 423.3.

701—18.2(422,423) Sales of butane, propane and other like gases in cylinder drums, etc. Sales of butane, propane and other like gases in cylinder drums and other similar containers purchased for cooking, heating and other purposes shall be taxable.

When gas of this type is sold and motor vehicle fuel tax is collected by the seller, tax shall not be due. If Iowa motor vehicle fuel tax is not collected by the seller at the time of the sale, tax shall be collected and remitted to the department, unless the sale is specifically exempt.

If tax is not collected by the seller at the time of sale, any tax due shall be collected by the department at the time the user of the product makes application for a refund of the motor vehicle fuel tax.

The gross receipts from the rental of cylinders, drums and other similar containers by the distributor or dealer of the gas shall be subject to tax when the title remains with the dealer. Gas converter equipment which might be sold to an ultimate consumer shall be subject to tax.

This rule is intended to implement Iowa Code sections 422.42, 422.43, 422.45(11), 423.1 and 423.2.

701—18.3(422,423) Chemical compounds used to treat water. Chemical compounds placed in water which is ultimately sold at retail should be purchased exempt from the tax. The chemical compounds become an integral part of property sold at retail. Chemical compounds placed in water which is directly used in processing are exempt from the tax, even if the water is consumed by the processor and not sold at retail.

Chemical compounds which are used to treat water that is not sold at retail or which are not used directly in processing shall be subject to tax. An example would be chlorine or other chemicals used to treat water for a swimming pool.

Special boiler compounds used by processors when live steam is injected into the mash or substance, whereby the steam liquefies and becomes an integral part of the product intended to be sold at retail and does become a part of the finished product, shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1, and 423.2.

701—18.4(422) Mortgages and trustees. Pursuant to the provisions of a chattel mortgage, the receipts from the sale of tangible personal property at a public auction shall be taxable even if the sale is made by virtue of a court decree of foreclosure by an officer appointed by the court for that purpose.

The tax applies to inventory and noninventory goods provided the owner is in the business of making retail sales of tangible personal property or taxable services. In *Re Hubs Repair Shop, Inc.* 28 B.R. 858 (Bkrtcy. 1983).

This rule is intended to implement Iowa Code sections 422.42, 422.43, 423.1 and 423.2.

701—18.5(423) Sales to federal, state, county, municipal, or tribal government or the government's agencies or instrumentalities.

18.5(1) Sales to government or agencies or instrumentalities.

a. A sale to a government or an agency or instrumentality of government occurs only if a government or an agency or instrumentality of government pursuant to a contract for sale, takes title

or ownership to tangible personal property or a specified digital product, or receives an enumerated taxable service as a buyer from a seller.

b. No sale to a government or an agency or instrumentality of government occurs if a government or an agency or instrumentality of government pays some portion of the sales price of the sale of tangible personal property, a specified digital product, or a taxable service but title to and ownership of the tangible personal property or specified digital product are transferred to or a taxable service is received by another person as a result of the sale.

c. Independent contractors who deal with agencies, instrumentalities, or other entities of government do not, by virtue of their contracting with those entities, acquire immunity or exemption from taxation for themselves. Sales to these contractors are still subject to tax. See rule 701—19.12(422,423) for rules concerning construction contracts with designated exempt entities.

18.5(2) *Sales by or to the federal government or its agencies or instrumentalities.*

a. The sales price of the sale of tangible personal property, specified digital products, or enumerated taxable services made directly by or to the United States government or to recognized agencies, departments, or instrumentalities of the United States government shall not be subject to sales tax.

b. The sales price of retail sales made directly to patients, inmates, or employees of an institution or department of the United States government are taxable, as the sales are not made directly to the government. However, sales similarly made by post exchanges and other establishments organized and controlled by federal authority shall not be subject to sales tax.

EXAMPLE 1: Patient B purchases a hospital bed from a drugstore. A percentage of Patient B's bill is paid by federal funds from Medicaid. Because Patient B, not the federal government, purchased the hospital bed, Iowa sales tax is due.

EXAMPLE 2: Employee C is a federal government employee who eats at a restaurant while on government business. Employee C pays for the meal with a credit card. The credit card was issued in Employee C's name, and the cost of the meal is billed to Employee C, who pays it. The federal government later reimburses Employee C the entire cost of the meal. Because Employee C, not the federal government, purchased the meal, Iowa sales tax is due.

EXAMPLE 3: Similar to Example 2, Employee D is a federal government employee who eats at a restaurant while on government business. Employee D uses a credit card to pay for the meal. However, the credit card is issued in Employee D's name, but the cost of the meal is billed to the federal government, which pays that cost. Here, the federal government is the purchaser of the meal on Employee D's behalf, and the sale is exempt from tax.

18.5(3) *Sales to the state of Iowa or its agencies or instrumentalities.* The sales price of sales to the state of Iowa or agencies, departments, or instrumentalities of the state of Iowa are not taxable when used for public purposes.

EXAMPLE 1: City X, an exempt instrumentality, issues a bond to finance the construction of a school. Corporation Y purchases the bond but is not involved in the project in any other way. Since City X does not enjoy the benefits of earnings of the school, the exemption provided to the city is applicable.

EXAMPLE 2: Corporation Z, an instrumentality of the federal government which Congress has allowed by statute to be subject to state sales and use taxes, purchases tangible personal property. These purchases are subject to tax because the profits of the corporation are distributed to the corporation's stockholders.

18.5(4) *Sales to a tribal government and its agencies or instrumentalities.* The sales price of tangible personal property, specified digital products, or enumerated taxable services furnished to a tribal government as defined in Iowa Code section 216A.161, or an agency or instrumentality of tribal government, shall not be subject to tax when used for public purposes.

18.5(5) *Sales by a municipal utility.*

a. The sales price of tangible personal property, specified digital products, or services used by or in connection with the operation of any municipally owned public utility engaged in selling gas, electricity, pay television service, or heat to the general public shall be subject to tax.

b. Sewage service or solid waste collection and disposal service provided to a county or municipality on behalf of nonresidential commercial operations located within the county or municipality shall also be subject to tax. See rules 701—26.71(423) and 701—26.72(423) for more information.

This rule is intended to implement Iowa Code section 423.3(31).
[ARC 5530C, IAB 3/24/21, effective 4/28/21]

701—18.6(422,423) Relief agencies.

18.6(1) Relief agency means the state, any county, city and county, city or district thereof, or any agency engaged in actual relief work. Nonexclusive examples of relief agencies are Salvation Army, Royal Neighbors, and Masonic Lodge. The sales of tangible personal property or enumerated services to relief agencies are subject to tax. A relief agency may apply to the director for refund of the amount of tax imposed and paid by it, upon the purchase of goods, wares, merchandise, or services rendered, furnished, or performed that are used for free distribution to the poor and needy.

18.6(2) Persons are determined to be in the poor and needy category when their incomes and resources are at or below poverty level. The department will use federal poverty guidelines in making this determination.

18.6(3) Listed below are some examples where the tax may or may not be refunded to the relief agency:

EXAMPLE: A relief agency purchases clothing for free distribution to a poor and needy person. The tax is refundable.

EXAMPLE: A relief agency pays the gas, light, or telephone bill for a person who is poor and needy. The tax is refundable.

EXAMPLE: An agency purchases items of clothing for residents of their living facility, and is partially reimbursed by the person using the items based upon the recipient's ability to pay. Tax on the portion of cost not recovered by the agency can be claimed as a refund of tax paid by using formula stated in 18.6(6).

18.6(4) Demolition v. repair costs. A nonprofit noneducational relief agency is not entitled to a refund of sales tax paid by contractors on building materials used in the alteration, expansion, repair, remodeling or construction of the facility since the materials were sold tax paid to the contractor who is the consumer of the material by statute. See Iowa Code section 422.42(9). However, the relief agency would be entitled to a refund of sales tax paid on the cost of the demolition of the building since the demolition of the building indirectly benefited the poor and needy. 1968 O.A.G. #841.

EXAMPLE: A relief agency, which is not part of a governmental unit, operates a home or orphanage for persons who are poor and needy or for orphan children. Food, lodging, and necessary items are furnished free-of-charge to the residents. The relief agency would be entitled to a refund of any taxes paid to operate this facility; such as, but not limited to, lights, heat, water, telephone, and repair items or services needed to maintain the facility.

18.6(5) Claims for refund must be filed quarterly with the department within 45 days after the end of the quarter for which the refund is claimed. Claims are to be submitted on forms provided by the department.

The claim shall include the following information:

a. The total amount or amounts, valued in money, expended directly or indirectly for goods, wares, merchandise, or services rendered, furnished, or performed used for free distribution to the poor and needy.

b. List the persons making the sales to the relief agency.

1. Include the date of the sale.

2. Include the total amount expended, itemizing sales tax.

3. Include the date of payment.

4. Include the check number, receipt number, or paid invoice verifying payment.

c. List the total operating income received (residents, donations, etc.)

d. List the operating income received from residents only.

e. The claim shall be signed by an authorized agent of the relief agency.

18.6(6) When a relief agency receives part of its operating income from the poor and needy it is serving, this income will be considered in computing the tax refund paid upon sales to it of products or services used for free distribution to the poor and needy.

To reasonably approximate the correct amount of tax to be refunded, where only a portion of the tax qualifies for refund, a formula will be used by the department. The prescribed formula the department will allow is operating income received from the poor and needy served divided by total operating income received. This percentage will be multiplied by the applicable gross receipts which are considered refundable to arrive at the correct amount of tax to be refunded.

If a person requests an alternative formula, the person shall first list the reasons why an alternative formula is necessary and, secondly, shall outline the proposed formula in detail. If approval is given, the department reserves the right to withdraw the approval or require adjustments in the formula upon notice to the person. Additional refunds or assessments may be made if an audit discloses the formula is incorrect.

This rule is intended to implement Iowa Code sections 422.42(7), 422.43, 422.47, 423.1 and 423.2.

701—18.7(422,423) Containers, including packing cases, shipping cases, wrapping material and similar items. The gross receipts from the sale of containers, labels, cartons, pallets, packing cases, wrapping paper, twine, bags, bottles, shipping cases, garment hangers, and other similar articles and receptacles sold to retailers or manufacturers which are purchased for the purpose of packaging or facilitating the transportation of tangible personal property which is sold either at retail or for resale shall be exempt from the tax.

For the purpose of this rule, producers, wholesalers and jobbers are considered retailers or manufacturers.

18.7(1) *Sales to other than retailers or manufacturers.*

a. Containers and all other specified items delivered with tangible personal property which are sold to a final buyer or ultimate consumer shall be exempt from the tax when no separate charge is made for the container. This group includes such items as boxes, cartons, pallets, paper bags, bottles, shipping cases, wrapping paper and twine. If a separate charge is made for the container, the sale of the container is subject to the tax. The sale of wrapping paper, paper bags and like items are subject to the tax when sold at retail.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers to whom meat is sold. The wrapping paper and tape would be exempt from tax as being purchased as a packaging material of tangible personal property sold at retail.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers who own the meat. The meat locker only performs the service of processing the meat. The wrapping paper and tape are subject to tax as they were not purchased for packaging or for the facilitating of transportation of tangible personal property sold at retail, but were used in the rendering of a service.

b. Packing paper, lining paper, paper used to line boxes and crates, and similar items shall be exempt from the tax if delivered with tangible personal property ultimately sold at retail when no separate charge is made for the paper.

18.7(2) *Labels, tags and nameplates.* Sales of labels, tags, and nameplates attached to products for the benefit of the vendor such as shipping tags, price tags and instructions to cashiers are subject to the tax, unless such items are sold to manufacturers and retailers for packaging or facilitating the transportation of tangible personal property ultimately sold at retail. Labels, tags or nameplates attached to products for the benefit of the final consumer which describe contents, or which relate to the product and are affixed to the product, are exempt from tax.

18.7(3) *Pallets.* Pallets purchased by manufacturers or retailers which are purchased for the purpose of packaging or facilitating the transportation of tangible personal property ultimately sold at retail shall be exempt from the tax.

18.7(4) *Garment hangers.* Garment hangers purchased by manufacturers or retailers and used to facilitate the transportation of tangible personal property or garment hangers delivered with tangible personal property ultimately sold at retail when no separate charge is made are exempt from tax.

Garment hangers used merely to display tangible personal property are taxable.

This rule is intended to implement Iowa Code sections 422.42(3), 422.45(19) and 423.1(1).

701—18.8(422) Auctioneers.

18.8(1) An auctioneer in making a sale, whether of tangible personal property or realty, is by virtue of this employment making the sale as the agent of the principal.

18.8(2) Where an auctioneer is conducting a sale and the principal meets the requirement of the casual sale exemption found in Iowa Code section 422.42(12), the gross receipts from the sale are exempt from the tax. See 1970 O.A.G. 774.

18.8(3) When an auctioneer is conducting a sale and the principal is in the business of making sales of tangible personal property or taxable services on a recurring basis, the gross receipts from the sale are taxable.

18.8(4) Where an auctioneer is selling tangible personal property that the auctioneer owns, the sale of the tangible property owned by the auctioneer is taxable.

This rule is intended to implement Iowa Code section 422.43.

701—18.9(422) Sales by farmers. The sale of grain, livestock or any other farm or garden product by the producer thereof ordinarily constitutes a sale for resale, processing or human consumption and shall not be subject to tax.

Farmers selling tangible personal property not otherwise exempt to ultimate consumers or users shall hold a permit and collect and remit sales tax on the gross receipts from their sales.

701—18.10(422,423) Florists.

18.10(1) Florists are engaged in the business of selling tangible personal property at retail and shall be liable for payment of tax measured by the receipts from the sale of flowers, wreaths, bouquets, potted plants and other items of tangible personal property.

18.10(2) When florists conduct transactions through a florists' telephonic delivery association, the following rules shall apply when computing tax liability:

a. On all orders taken by an Iowa florist and telephoned to a second florist in Iowa for delivery in the state, the sending florist shall be liable for tax, measured at the current rate of tax on gross receipts from the total amount collected from the customer, except the cost of a telegram when a separate charge is made therefor.

b. In cases where a florist receives an order pursuant to which the florist gives telephonic instructions to a second florist located outside Iowa for delivery to a point outside Iowa, tax is not owing with respect to any receipts which the florist may realize from the transaction.

c. In cases where Iowa florists receive telephonic instructions from other florists located either within or outside of Iowa for the delivery of flowers, the receiving florist will not be held liable for tax with respect to any receipts which the florist may realize from the transaction.

d. Rescinded IAB 2/28/96, effective 4/3/96.

18.10(3) Florists engaged in selling shrubbery, trees, and similar items. See rule 18.11(422,423).

This rule is intended to implement Iowa Code section 422.43.

701—18.11(422,423) Landscaping materials. The gross receipts from the sale of sod, dirt, trees, shrubbery, bulbs, sand, rock, woodchips and other similar landscaping materials, when used for landscaping and sold to final consumers, shall be subject to sales tax. For the purpose of this rule, "final consumer" ordinarily means the owner of the land to which the landscaping materials are applied, or a general building contractor when the landscaping contractor contracts with the general building contractor. When a landscaping contractor uses materials to fulfill a contract, the landscape contractor

is considered the retailer of the landscaping materials and shall be obligated to collect sales tax on the selling price from the final consumer.

When the retailer of sod, dirt, trees, shrubbery, bulbs, sand, rock, woodchips and other similar landscaping materials installs these items as a part of a contract for landscaping or improving land for a lump sum, the entire gross receipts shall be subject to tax. Any retailer's charges for "landscaping" shall be taxable. See rule 701—26.62(422) for a description of this service. However, a retailer's charges for nontaxable services are not taxable if contracted for separately; or, if no written contract exists, the charges are itemized separately on the invoice.

EXAMPLE: A sodding contractor agrees to furnish and install 20 yards of sod for the lump sum of \$20.00 per yard. The sodding contractor must charge the customer \$20.00 sales tax (5% x \$400.00).

EXAMPLE: XYZ Company enters into a contract for the landscaping of an existing office building. XYZ Company agrees to furnish shrubs at \$25.00 each, white rock for \$5.00 per bag and woodchips for \$4.00 per bag. XYZ Company also contracts to install all of the landscaping materials for a fee of \$25.00 per hour. XYZ Company's hourly fee is taxable if paid for the service of "landscaping" or for some other taxable service, e.g., excavation. If the service is not taxable, the charge is excluded from tax because it was separately contracted for.

The gross receipts from the sale of uncut sod and unexcavated trees, shrubs, and rock shall not be subject to sales or use tax. This is considered a sale of intangible property and not the sale of tangible personal property.

This rule does not apply to the gross receipts from the sale of plants and trees which are eligible for purchase with food coupons under rule 701—20.1(422,423).

This rule is intended to implement Iowa Code sections 422.42, 422.45(12) and 423.1.

701—18.12(422,423) Hatcheries. The gross receipts from the sale of egg-type cockerel chicks, broiler chicks and turkey poults shall be subject to tax. If sale of domestic poultry is for breeding, see rule 701—17.9(422,423).

When pullets and poults are sold for production purposes, the receipts from the sales shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.13(422,423) Sales by the state of Iowa, its agencies and instrumentalities. The state of Iowa, its agencies and instrumentalities, are required to collect and remit tax on the gross receipts from taxable retail sales of tangible personal property and taxable services.

This rule does not apply to sales made by cities and counties in the state of Iowa which are specifically exempted from collecting tax by Iowa Code section 422.45(20).

This rule is intended to implement Iowa Code chapters 422 and 423.

701—18.14(422,423) Sales of livestock and poultry feeds. Tax shall not apply to the sale of feed for any form of animal life when the product of the animals constitutes food for human consumption. Tax shall apply on feed sold for consumption by pets.

Antibiotics, when administered as an additive to feed or drinking water, and vitamins and minerals sold for livestock and poultry shall be exempt from tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.15(422,423) Student fraternities and sororities. Student fraternities and sororities are not considered to be engaged in the business of selling tangible personal property at retail within the meaning of the sales tax law when they provide their members with meals and lodging for which a flat rate or lump sum is charged. A person engaged in the selling of foods and beverages to such organizations for use in the preparation of meals is making exempt sales at retail and shall not be liable for tax if the food purchases would be exempt under rule 701—20.1(422,423).

Student fraternities or sororities engaged in the business of serving meals to persons other than members for which separate charges are made, or owning and operating canteens through which tangible personal property is sold are deemed to be making taxable sales.

When student fraternities or sororities do not provide their own meals but are provided by caterers, concessionaires or other persons, such caterers, concessionaires or other persons shall be liable for the collection and remittance of tax with respect to their receipts from meals furnished. A similar liability is attached to persons engaged in the business of operating boarding houses, whether for students or other persons.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.16(422,423) Photographers and photostaters. Tax shall apply to the sale of photographs and photostat copies, whether or not produced to the special order of the customer and to charges for the making of photographs or photostat copies out of materials furnished by the customer. A deduction shall not be allowed for the expenses incurred by the photographer, such as rental of equipment or salaries or wages paid to assistants or models, whether or not the expenses are itemized in billings to customers.

Tax shall not apply to the sale of tangible personal property to photographers and photostat producers which becomes an ingredient or component part of photographs or photostat copies sold, such as mounts, frames and sensitized paper; but tax shall apply to the sale of materials to photographers or producers which is used in the processing of photographs or photostat copies.

18.16(1) *Sales of photographs to newspaper or magazine publishers for reproduction.* The sale of photographs by a person engaged in the business of making and selling photographs to newspaper or magazine publishers for reproduction shall be taxable.

18.16(2) Reserved.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.17(422,423) Gravel and stone. When a contract is entered between a contractor and a governmental body and the contract calls for a stockpile delivery along a road to be improved, it is a sale of tangible personal property to the governmental body. Transactions of this type are exempt from tax. When a contract not only provides for the sale and delivery of materials but also the conversion of the materials into realty improvements, the contractor is the ultimate consumer of the material used and shall be liable for tax. Tax shall apply on the purchase price of the material.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(5), 423.1 and 423.2.

701—18.18(422,423) Sale of ice. The sale of ice for human consumption which may be purchased with food coupons is exempt from tax. The sale of ice used for cooling is subject to tax. See rule 701—20.1(422,423).

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(12), 423.2 and 423.4.

701—18.19(422,423) Antiques, curios, old coins or collector's postage stamps. Curios, antiques, art work, coins, collector's postage stamps and such articles sold to or by art collectors, philatelists, numismatists and other persons who purchase or sell such items of tangible personal property for use and not primarily for resale are sales at retail and shall be subject to tax.

18.19(1) Stamps, whether canceled or uncanceled, which are sold by a collector or person engaged in retailing stamps to collectors shall be taxable.

18.19(2) The distinction between stamps which are purchased by a collector and stamps which are purchased for their value as evidence of the privilege of the owner to have certain mail carried by the United States government is that which determines whether or not a stamp is taxable or not taxable. A stamp becomes an article of tangible personal property having market value when, because of the demand, it can be sold for a price greater than its face value. On the other hand, when a stamp has only

face value, as evidence of the right to certain services or an indication that certain revenue has been paid, it shall not be subject to either sales or use tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.20(422,423) Communication services. This rule applies to sales of communication services billed prior to November 23, 2011. For communication service, telecommunication service, ancillary service and other related communication service billed on or after November 23, 2011, refer to 701—Chapter 224, Iowa Administrative Code. The gross receipts from the sale of all communication services provided in this state are subject to tax. (Communication services are not subject to use tax prior to July 1, 2001. See rule 701—31.7(423).)

18.20(1) Definitions.

a. Communication service shall mean the act of providing, for a consideration, any medium or method for, or the act of transmission and receipt of, information between two or more points. Each point must be capable of both transmitting and receiving information if “communication” is to occur. The term “communication service” includes, but is not limited to, the transmission and receipt of sound, printed materials (including letters and materials printed by teletype), other images perceived visually and data encoded in computer languages. Any separate charge for the service of transmitting and receiving information between automatic data processing equipment and remote facilities shall be subject to tax, see paragraph 18.34(3) “c.”

b. Communication service is provided “in this state” only if both the points of origination and termination of the communication are within the borders of Iowa. Communication service between any other points is “interstate” in nature and not subject to tax.

c. “Gross receipts” from the sale of communication service in this state shall mean all charges to any person which are necessary for the ultimate user to secure the service, except those charges which are in the nature of a sale for resale (see subrule 18.20(4)). Such charges shall be taxable if the charges are necessary to secure communication service in this state even though payment of the charge may also be necessary to secure other services. Any charge necessary to secure only interstate communication service shall not be subject to tax if the nature of the service is separately stated and the charge for the service separately billed. For the present, the charges imposed by the Federal Communications Commission and referred to as “access charges for interstate or foreign access services” to an “end user” shall not be subject to tax if separately stated and billed.

Charges imposed or approved by the utilities division of the department of commerce which are necessary to secure long distance service in this state, for example, “end user intrastate access charges,” are taxable. Such charges are taxable whether they result from an expense incurred from operations or are imposed by the mandate of the utilities division and unrelated to any expense actually incurred in providing the service.

If company A collects gross receipts from ultimate users for communication services performed in this state by company B, company A shall treat those gross receipts as its own, collect tax upon them, and remit the tax to the department. The situation is similar to a consignment sale of tangible personal property, and tax must be remitted by the company collecting the gross receipts from the users of the communication services.

d. Paging services. A one-way paging service is not a taxable enumerated service in Iowa because one-way paging only receives information and is not capable of transmitting information. As a result, this type of pager service is not a two-way transmission.

18.20(2) This subrule is applicable to various specific circumstances involving the sale of communication services.

a. Companies which bill their subscribers for communication services on a quarterly, semiannual, annual or any other periodic basis shall include the amount of such billings in their gross receipts. The date of the billing shall determine the period for which sales tax shall be remitted. Thus, if the date of a billing is March 31, and the due date for payment of the bill without penalty is April 20, tax upon the gross receipts contained in the bill shall be included in the sales tax return for the first quarter of the

year. The same principle shall be used to determine when tax will be included in payment of a sales tax deposit to the department.

b. The gross receipts from the service of transmitting messages, night letters, day letters and all other messages of similar nature between two or more points within this state are subject to sales tax.

c. Receipts from communication services performed for all divisions, boards, commissions, agencies or instrumentalities of federal, Iowa, county or municipal government, and private, nonprofit educational institutions in this state for educational purposes are exempt from tax, except sales to any tax-levying body used by or in connection with the operation of any municipally owned utility engaged in selling gas, electricity or heat to the general public are subject to tax.

18.20(3) This subrule is specifically applicable to companies and other persons providing telephone service in this state. Any reasoning contained in this subrule may also be applied to companies or other persons providing other communication services.

a. All companies must have a permit for each business office which provides communication service in this state. The companies must collect and remit tax upon the gross receipts from the operation of such offices.

b. If a minimum amount is guaranteed to a company from the operation of any coin-operated telephone, tax shall be computed on the minimum amount guaranteed or the actual taxable gross receipts collected whichever is the greater.

c. In computing tax due, the federal taxes identified as such, separately billed and payable by the customer shall be excluded from gross receipts. If the taxes are not separately billed, they shall be subject to Iowa sales tax.

d. Telegrams and like charges made to the accounts of subscribers and billed by companies providing telephone service which appear on the subscribers' toll bills are subject to tax.

e. Charges for directory assistance service rendered in this state shall be subject to tax. Charges for directory assistance service, separately stated and billed, shall not be subject to tax if the service is interstate in nature.

f. The gross receipts from the installation or repair of any inside wire which provides electrical current that allows an electronics device to function shall be subject to tax. Such gross receipts are from the enumerated service of electrical repair or installation, and are thus subject to tax. The gross receipts from "inside wire maintenance charges" for services performed under a service or warranty contract shall also be subject to tax. Depending on circumstances, such receipts are for the enumerated service of "electrical repair" or are incurred under an "optional service or warranty contract" for an enumerated service. In either event, the receipts are subject to tax. See rule 701—18.25(422,423).

g. The gross receipts from the rental of any device for home or office use or to provide a communication service to others shall be fully taxable; such receipts are for the enumerated service of "rental of tangible personal property." The gross receipts from rental include rents, royalties, and copyright and license fees. Any periodic fee for maintenance of the device which is included in the gross receipts for the rental of the device shall also be subject to tax.

h. The sale of any device, new or used, in place at the time of sale on the customer's premises or sold to the customer elsewhere is the sale of tangible personal property, and thus a sale subject to tax. The sale of an entire inventory of devices may or may not be subject to tax, depending upon whether it does or does not come within the purview of the casual sales exemption, see Iowa Code section 422.42(2) and subrule 18.28(3). Other exemptions may be applicable as well. See Iowa Code section 422.45 and 701—Chapter 17.

i. The gross receipts for the repair or installation of inside wire or the repair or installation of any electronic device, including a telephone or telephone switching equipment shall, as a general rule, be subject to tax whether the customer or purchaser is billed by way of a flat fee or flat hourly charge covering all costs including labor and materials, or by way of a premises visit or trip charge, or by a single charge covering and not distinguishing between charges for labor and materials, or is billed by a charge with labor and material segregated, or is billed for labor only. An exception is this: If the gross receipts are for services on or in connection with new construction, reconstruction, alteration, expansion or remodeling of a building or structure, the gross receipts shall not be subject to tax. For

further information concerning the conditions under which such gross receipts for repair or installation would not be subject to tax, see rule 701—19.1(422,423) and 701—subrule 26.2(1).

j. If a company bills a handling charge to a customer for sending the customer an electronic device by mail or by a delivery service, this charge shall constitute a part of the gross receipts from the sale of the device and shall be subject to tax. The gross receipts of a mandatory service rendered in connection with the sale of tangible personal property are considered by the department to be a part of the gross receipts from the sale of the property itself and thus subject to tax.

k. The purchase or rental of tangible personal property by companies providing communication services shall be subject to tax.

l. The amount of any deposit paid by a customer to a company providing communication service if returned to the customer shall not be subject to tax. Any portion of a deposit utilized by a company as payment for the sale of tangible personal property or a taxable service shall be included in gross receipts or gross taxable services and shall be subject to tax.

m. On and after July 1, 1997, the gross receipts from sales of prepaid telephone calling cards and prepaid authorization numbers are subject to tax as sales of tangible personal property.

18.20(4) When one commercial communication company furnishes another commercial communication company services or facilities which are used by the second company in furnishing communication service to its customers, such services or facilities furnished to the second company are in the nature of a sale for resale; and the charges, including any carrier access charges, shall be exempt from sales tax. The charges for services or facilities initially purchased for resale and subsequently used or consumed by the second company shall be subject to tax, and the tax shall be collected and paid by the seller unless the seller has taken a valid exemption certificate in good faith from the purchaser and other requirements of 701—subrule 15.3(2) are met.

18.20(5) Prior to July 1, 1999, charges for access to or use of what is commonly referred to as the “Internet” or charges for other contracted on-line services are the gross receipts from the performance of a taxable service if access is by way of a local or in-state long distance telephone number and if the predominant service offered is two-way transmission and receipt of information from one site to another as described in paragraph “a” of subrule 18.20(1). If a user’s billing address is located in Iowa, a service provider should assume that Internet access or contracted on-line service is provided to that user in Iowa unless the user presents suitable evidence that the site or sites at which these services are furnished are located outside this state.

On and after July 1, 1999, gross receipts from charges paid to a provider for access to an on-line computer service are exempt from tax. An “on-line computer service” is one which provides for or enables multiple users to have computer access to the Internet. Charges paid to a provider for other contracted on-line services which do not provide access to the Internet and which are communication services remain subject to Iowa tax through May 14, 2000.

On and after May 15, 2000, the furnishing of any contracted on-line service is exempt from Iowa tax if the information is made available through a computer server. The exemption applies to all contracted on-line services, as long as they provide access to information through a computer server.

18.20(6) The gross receipts paid for the performance of the service of sending or receiving any document commonly referred to as a “fax” from one point to another within this state are subject to sales tax. See 18.20(1)“a.” Gross receipts paid for the service of providing a telephone line or other transmission path for the use of what is commonly called a “fax” machine are the gross receipts from the performance of a taxable service if the points of transmission and receipt of a fax are in this state. See 18.20(1)“a” and “b.”

EXAMPLE A. Klear Kopy Services is located in Des Moines, Iowa. Klear Kopy charges a customer \$2 to transmit a fax (via its machine) to Dubuque, Iowa. The \$2 is taxable gross receipts. Midwest Telephone Company charges Klear Kopy \$500 per month for the intrastate communications on Klear Kopy’s dedicated fax line. The \$500 is also gross receipts from a taxable communication service.

EXAMPLE B. The XYZ Law Firm is located in Des Moines, Iowa. The firm owns a fax machine and uses the fax machine in the performance of its legal work to transmit and receive various documents. The firm does not perform faxing services but will, on billings for legal services to clients, break out the

amount of a billing which is attributable to expenses for faxing. For example, “bill to John Smith for August, 1997, \$1,000 for legal services performed, fax expenses which are part of this billing—\$30.” The \$30 is not gross receipts for the performance of any taxable service, the faxing service performed being only incidental to the performance of the nontaxable legal services.

EXAMPLE C. The TUV Hospital is located in Cedar Rapids, Iowa. The surgeons successfully perform delicate brain surgery on patient W. To perform that surgery it was necessary for the surgeons to consult with a number of colleagues; the consultation was via email. After the operation, the TUV Hospital sent patient W a bill for \$10,000 of nontaxable hospital services. Listed as an expense is “email—\$200.” The email services are performed incidentally to the nontaxable hospital services; therefore, the \$200 is not taxable gross receipts.

EXAMPLE D. D is a dentist practicing in Mason City, Iowa. D subscribes to an on-line service which, in return for a monthly fee, informs its subscribers of the latest dental surgery techniques and advises them about how these techniques can be applied to individual patients. After consultation on patient E’s problem through the on-line service, D performs complex surgery on patient E. D’s bill to patient E reads as follows: “dental reconstruction—\$2,750; on-line consultation portion—\$240.” The \$240 is not taxable gross receipts, this charge being incidental to the nontaxable charge for dental work.

18.20(7) *Communication service, telecommunications service, ancillary service, and other similar communication service.*

a. Purpose. This subrule covers various provisions related to communication service, telecommunications service, ancillary service, and other similar communication service.

b. Definitions.

(1) “*Air-to-ground radio telephone service*” means a radio service in which common carriers are authorized to offer and provide radio telecommunications service for hire to subscribers in aircraft.

(2) “*Ancillary services*” means services that are associated with or incidental to the provision of a telecommunications service. The term includes, but is not limited to, detailed communications billing service, directory assistance, vertical service, and voice mail services.

(3) “*Call-by-call basis*” means any method of charging for telecommunications services where the price is measured by individual calls.

(4) “*Communications channel*” means a physical or virtual path of communications over which signals are transmitted between or among customer channel termination points.

(5) “*Communication service*” means the act of communicating using any system or the act of transmission and receipt of information between two or more points. Each point must be capable of both transmitting and receiving information if communication is to occur. The term “communication service” includes, but is not limited to, the transmission and receipt of sound, printed materials (including letters and other materials), other images perceived visually and data encoded in computer languages. Communication service also includes telecommunications service, ancillary service and other similar communication service.

(6) “*Conference bridging service*” means an ancillary service that links two or more participants of an audio or video conference call and may include the provision of a telephone number. Conference bridging service does not include telecommunications services used to reach the conference bridge.

(7) “*Customer*” means the person or entity that contracts with the seller of telecommunications services. If the end user of telecommunications services is not the contracting party, the end user of the telecommunications service is the customer of the telecommunications service. For purposes of sourcing sales of telecommunications services, the end user of the telecommunications service is the customer of the telecommunications service when the end user is not also the contracting party. “Customer” does not include a reseller of telecommunications service or for mobile telecommunications service of a serving carrier under an agreement to serve the customer outside the home service provider’s licensed service area.

(8) “*Customer channel termination point*” means the location where the customer either inputs or receives the communications.

(9) “*Detailed telecommunications billing service*” means an ancillary service of separately stating information pertaining to individual calls on a customer’s billing statement.

(10) “*Directory assistance*” means an ancillary service of providing telephone number information and address information.

(11) “*End user*” means the person who utilizes the telecommunication service. In the case of an entity, “end user” means the individual who utilizes the service on behalf of the entity.

(12) “*Fixed wireless service*” means a telecommunications service that provides radio communication between fixed points.

(13) “*Home service provider*” means the same as defined in Section 124(5) of Public Law 106-252, 4 U.S.C. § 124(5) (Mobile Telecommunications Sourcing Act). The home service provider is the facilities-based carrier or reseller with which the customer contracts for the provision of mobile telecommunications services.

(14) “*Interstate*” means a telecommunications service that originates in one United States state or a United States territory or possession and terminates in a different United States state or a United States territory or possession.

(15) “*Intrastate*” means a telecommunications service that originates in one United States state or a United States territory or possession and terminates in the same United States state or a United States territory or possession.

(16) “*Mobile telecommunications service*” means commercial mobile radio service; that is, a radio communication service carried on between mobile stations or receivers and land stations and by mobile stations communicating among themselves.

(17) “*Mobile wireless service*” means a telecommunications service that is transmitted, conveyed, or routed regardless of the technology used, whereby the origination and/or termination points of the transmission, conveyance, or routing are not fixed, including, by example only, telecommunications services that are provided by a commercial mobile radio service provider.

(18) “*Paging service*” means a telecommunications service that provides transmission of coded radio signals for the purpose of activating specific pagers. This transmission may include messages and sounds.

(19) “*Pay telephone service*” means a telecommunications service provided through any pay telephone. Pay telephone service also includes coin operated telephone service paid for by inserting money into a telephone accepting direct deposits of money to operate.

(20) “*Place of primary use*” means the street address representative of where the customer’s use of the telecommunications service primarily occurs, which must be the residential street address or the primary business street address of the customer. In the case of mobile telecommunications services, the place of primary use must be within the licensed service area of the home service provider.

(21) “*Postpaid calling service*” means the telecommunications service obtained by making a payment on a call-by-call basis, either through use of a credit card or payment mechanism such as a bank card, travel card, credit card or debit card, or by charge made to a telephone number which is not associated with the origination or termination of the telecommunications service. A postpaid calling service includes a telecommunications service, except a prepaid wireless calling service that would be a prepaid calling service except it is not exclusively a telecommunication service.

(22) “*Prepaid calling service*” means the right to access exclusively telecommunications services, which must be paid for in advance and which enable the origination of calls using an access number or authorization code, whether manually or electronically dialed, and that are sold in predetermined units or dollars of which the number declines with use in a known amount.

(23) “*Prepaid wireless calling service*” means a telecommunications service that provides the right to utilize mobile wireless service as well as other non-telecommunications services, including the download of digital products delivered electronically, content and ancillary services, which must be paid for in advance that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(24) “*Private communication service*” means a telecommunication service that entitles the customer to exclusive or priority use of a communications channel or group of channels between or among termination points, regardless of the manner in which such channel or channels are connected,

and includes switching capacity, extension lines, stations, and any other associated services that are provided in connection with the use of such channel or channels.

(25) “*Residential telecommunications service*” means a telecommunications service or ancillary services provided to an individual for personal use at a residential address, including an individual dwelling unit, such as an apartment. In the case of institutions where individuals reside, such as schools or nursing homes, telecommunications service is considered residential if it is provided to and paid for by an individual resident rather than the institution.

(26) “*Service address*” means:

1. The location of the telecommunications equipment to which a customer’s call is charged and from which the call originates or terminates, regardless of where the call is billed or paid.

2. If the location in numbered paragraph “1” of this subparagraph is not known, “service address” means the origination point of the signal of the telecommunications services first identified by either the seller’s telecommunications system or in information received by the seller from its service provider, where the system used to transport such signals is not that of the seller.

3. If the locations in numbered paragraphs “1” and “2” of this subparagraph are not known, the service address means the location of the customer’s place of primary use.

(27) “*Telecommunications service*” means the electronic transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals to a point, or between or among points. The term includes any transmission, conveyance, or routing in which computer processing applications are used to act on the form, code, or protocol of the content for purposes of transmission, conveyance, or routing without regard to whether such service is referred to as voice-over Internet protocol services or is classified by the Federal Communications Commission as enhanced or value-added. “Telecommunications service” does not include the following:

1. Data processing and information services that allow data to be generated, acquired, stored, processed, or retrieved and delivered by an electronic transmission to a purchaser where the purchaser’s primary purpose for the underlying transaction is the processed data or information;

2. Installation or maintenance of wiring or equipment on a customer’s premises;

3. Tangible personal property;

4. Advertising, including but not limited to directory advertising;

5. Billing and collection services provided to third parties;

6. Internet access service;

7. Radio and television audio and video programming services, regardless of the medium, including the furnishing of transmission, conveyance, or routing of the service by the programming service provider. Radio and television audio and video programming services shall include, but not be limited to, cable service and audio and video programming services delivered by a commercial mobile radio service provider;

8. Ancillary service;

9. Digital products delivered electronically, including but not limited to software, music, video, reading materials or ring tones.

(28) “*Value-added non-voice data service*” means a service that otherwise meets the definition of telecommunications services in which computer processing applications are used to act on the form, content, code, or protocol of the information or data primarily for a purpose other than transmission, conveyance, or routing.

(29) “*Vertical service*” means an ancillary service that is offered in connection with one or more telecommunications services, which offers advanced calling features that allow customers to identify callers and to manage multiple calls and call connections. Nonexclusive examples of vertical service include call forwarding, caller ID, three-way calling, and conference bridging services.

(30) “*Voice mail service*” means an ancillary service that enables the customer to store, send, or receive recorded messages. Voice mail service does not include any vertical services that the customer may be required to have in order to utilize the voice mail service.

c. *Taxable communication service, telecommunications service, ancillary service, and other similar communication service.* The sales price from the sale of communication service,

telecommunications service, ancillary service, and other similar communication service is subject to the sales or use tax. The following is a nonexclusive list of services subject to the Iowa sales and use tax:

- (1) Air-to-ground radio telephone service;
- (2) Ancillary services except detailed communications billing service;
- (3) Conference bridging service;
- (4) Fixed wireless service;
- (5) Mobile wireless service;
- (6) Pay telephone service;
- (7) Postpaid calling service;
- (8) Prepaid calling service;
- (9) Prepaid wireless calling service;
- (10) Private communication service;
- (11) Residential telecommunications service.

d. Nontaxable communication service, telecommunications service, ancillary service, and other similar communication service. The following services are not subject to the Iowa sales and use tax:

- (1) Detailed communications billing service;
- (2) Internet access fees or charges;
- (3) One-way paging services that only receive information and are not capable of transmitting information;
- (4) Value-added non-voice data service;
- (5) Any charge necessary to secure only interstate communication service if the nature of the service is separately stated and the charge for the interstate service is separately billed.

e. Sourcing of telecommunications services.

(1) General sourcing principles apply to telecommunications services unless the service falls under one of the exceptions set out in paragraph “e.”

(2) Exceptions. The following telecommunications services and products are sourced in accordance with the principles set out in subparagraph (2):

1. Mobile telecommunications service is sourced to the place of primary use, unless the service is prepaid wireless calling service.

2. Prepaid calling service is sourced as provided under Iowa Code section 423.15. However, if the seller has sufficient information available, the sale of prepaid wireless calling service may be sourced to the location of the place of primary use.

3. A sale of a private telecommunications service is sourced as follows:

- Service for a separate charge related to a customer channel termination point is sourced to each level of jurisdiction in which the customer channel termination point is located.

- Service where all customer termination points are located entirely within one jurisdiction or levels of jurisdiction is sourced in the jurisdiction in which the customer channel termination points are located.

- Service for segments of a channel between two customer channel termination points located in different jurisdictions and which segments of channel are separately charged is sourced 50 percent in each level of jurisdiction in which the customer channel termination points are located.

- Service for segments of a channel located in more than one jurisdiction or levels of jurisdiction and which segments are not separately billed is sourced in each jurisdiction based on the percentage determined by dividing the number of customer channel termination points in the jurisdiction by the total number of customer channel termination points.

4. The sale of Internet access service is sourced to the customer’s place of primary use.

5. The sale of an ancillary service is sourced to the customer’s place of primary use.

6. A postpaid calling service is sourced to the origination point of the telecommunications signal as first identified by either (a) the seller’s telecommunications system or (b) information received by the seller from its service provider, where the system used to transport the signals is not that of the seller.

7. The sale of telecommunications service sold on a call-by-call basis is sourced to (a) each level of taxing jurisdiction where the call originates and terminates in that jurisdiction or (b) each level of

taxing jurisdiction where the call either originates or terminates and in which the service address is also located.

8. The sale of telecommunications services sold on a basis other than a call-by-call basis is sourced to the customer's place of primary use.

9. The sale of the following telecommunication services is sourced to each level of taxing jurisdiction as follows:

- A sale of mobile telecommunications services, other than prepaid calling service, is sourced to the customer's place of primary use as required by the federal Mobile Telecommunications Sourcing Act.

- A sale of postpaid calling service is sourced to the origination point of the telecommunications signal as first identified by either (a) the seller's telecommunications system or (b) information received by the seller from its service provider, where the system used to transport such signals is not that of the seller.

f. Bundled transaction.

(1) A "bundled transaction" is the retail sale of two or more products where (a) the products are otherwise distinct and identifiable, and (b) the products are sold for one non-itemized price. A bundled transaction does not include the sale of any products in which the sales price varies or is negotiable based on the selection by the purchaser of the products included in the transaction.

(2) In the case of a bundled transaction that includes any of the following: telecommunications service, ancillary service, Internet access, or audio or video programming service:

1. If the price is attributable to products that are taxable and products that are nontaxable, the portion of the price attributable to the nontaxable products will be subject to tax unless the provider can identify by reasonable and verifiable standards such portion from its books and records that are kept in the regular course of business for other purposes, including, but not limited to, non-tax purposes.

2. If the price is attributable to products that are subject to tax at different tax rates, the total price may be treated as attributable to the products subject to tax at the highest tax rate unless the provider can identify by reasonable and verifiable standards the portion of the price attributable to the products subject to tax at the lower rate from its books and records that are kept in the regular course of business for other purposes, including but not limited to non-tax purposes.

3. The provisions of this subrule shall apply unless otherwise provided by federal law.

g. Direct pay permit. The department may issue a direct pay permit that allows the holder to purchase tangible personal property or taxable services without payment of the tax to the seller. The direct pay permit holder cannot use the direct pay permit for the purchase of communication service, telecommunications service, ancillary services, or other similar communication service. The seller should charge and collect the sales or use tax from the purchaser on the taxable sales of communication service, telecommunications service, ancillary services, and other similar communication service.

h. Credit. A taxpayer subject to sales or use tax on communication service, telecommunications service, ancillary service or other similar communication service who has paid any legally imposed sales or use tax on such service to another jurisdiction outside the state of Iowa is allowed a credit against the sales or use tax imposed by the state of Iowa equal to the sales or use tax paid to the other taxing jurisdictions.

i. Sales of communication service, telecommunications service, ancillary service, or other similar communication service to the United States government or the state government of Iowa. Sales of communication service, telecommunications services, ancillary services, or other similar communication service to the United States government or its agencies or to the state of Iowa or its agencies are not subject to sales or use tax. In order to be a sale to the United States government or to the state government of Iowa, the government or agency involved must make the purchase of the services and pay directly to the vendor the purchase price of the services. Telecommunications service providers should obtain an exemption certificate from each agency for their records.

j. Retailers liable for collecting and remitting tax. Retailers that sell taxable communication service, telecommunications service, ancillary services, or other similar communication service are

liable for collecting and remitting the state sales or use tax and any applicable local sales tax on the amounts of the sales.

This rule is intended to implement Iowa Code sections 34A.7(1)“c”(2), 422.42(2), 422.42(3), 422.43(9), 422.45(5), 422.45(8), 422.45 and 422.51(1) and Iowa Code Supplement section 422.45 as amended by 2000 Iowa Acts, chapter 1189, section 29.

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701—18.21(422,423) Morticians or funeral directors. A mortician or funeral director is engaged in the business of selling both tangible personal property and funeral services. Examples of the former are caskets, other burial containers, flowers, and grave clothing. Examples of the latter are cremation, transportation by hearse and embalming. Tax is due only upon gross receipts from the sale of tangible personal property and taxable services, and not upon gross receipts from the sale of nontaxable services.

If a mortician or funeral director separately itemizes charges for tangible personal property, taxable services and nontaxable services, as required by the rules of the Federal Trade Commission, or Iowa Code section 523A.8(1)“b,” whichever is applicable, tax is due only upon the gross receipts from the sales of tangible personal property and taxable services. If contrary to the rules or the statute, or if the applicable rules are rescinded or the statute repealed, and the mortician or funeral director charges a lump sum to a customer covering the entire cost of the funeral without dividing the charges for sales of tangible personal property and taxable and nontaxable services, the mortician or funeral director shall report the full amount of the funeral bill less any cash advanced by the mortician or funeral director, with tax due on 50 percent of the difference. *Kistner v. Iowa State Board of Assessment and Review*, 224 Iowa 404, 280 N.W. 587 (1938). Cash advance items may include, but are not limited to, the following: cemetery or crematory services, pallbearers, public transportation, clergy honoraria, flowers, musicians, singers, nurses, obituary notices, gratuities, and death certificates.

The mortician or funeral director is considered to be purchasing caskets, outer burial containers, and grave clothing for resale, and may purchase these items from suppliers without payment of tax. The mortician or director should present the supplier with a certificate of resale as set out in rule 701—15.3(422,423). A mortician or director is considered to be the user or consumer of office furniture and equipment, funeral home furnishings, advertising calendars, booklets, motor vehicles and accessories, embalming equipment, instruments, fluid and other chemicals used in embalming, cosmetics, and grave equipment, stretchers, baskets, and other items if title or possession does not pass to the customer. *Kistner*; *supra*.

For purposes of this rule, the terms of morticians or funeral directors shall also include cemeteries, cemetery associations and anyone engaged in activities similar to those discussed in the rule.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 423.1 and 423.2.

701—18.22(422,423) Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians. Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians shall not be liable for tax on services rendered such as examinations, consultations, diagnosis, surgery and other kindred services, nor on the applicable exemptions prescribed under 701—Chapter 20.

The purchase of materials, supplies, and equipment by these persons is subject to tax unless the particular item is exempt from tax when purchased by an individual for the individual’s own use. For example, the purchase for use in the office of prescription drugs would not be subject to tax nor would the purchase of prosthetic devices such as artificial limbs or eyes.

Sales of tangible personal property to dentists, which are to be affixed to the person of a patient as an ingredient or component part of a dental prosthetic device, are exempt from tax. These include artificial teeth, and facings, dental crowns, dental mercury and acrylic, porcelain, gold, silver, alloy, and synthetic filling materials.

Sales of tangible personal property to physicians or surgeons, which are prescription drugs to be used or consumed by a patient, are exempt from tax.

Sales of tangible personal property to ophthalmologists, oculists, optometrists, and opticians, which are prosthetic devices designed, manufactured, or adjusted to fit a patient, are exempt from tax. These include prescription eyeglasses, contact lenses, frames, and lenses.

The purchase by such persons of materials such as pumice, tongue depressors, stethoscopes, which are not in themselves exempt from tax, would be subject to tax when purchased by such professions.

The purchase of equipment, such as an X-ray machine, X-ray photograph or frames for use by such persons is subject to tax. On the other hand, the purchase of an item of equipment that is utilized directly in the care of an illness, injury or disease, which item would be exempt if purchased directly by the patient, is not subject to tax.

This rule is intended to implement Iowa Code sections 422.42(3), 422.43, 422.45(13-15), 423.2 and 423.4(4).

701—18.23(422) Veterinarians. Purchase of food, drugs, medicines, bandages, dressings, serums, tonics, and the like, but not to include tools and equipment, which are used in treating livestock raised as part of agricultural production is exempt from tax. Where these same items are used in treating animals maintained as pets for hobby purposes, sales tax is due. See rule 701—18.48(422,423) for an exemption for machinery used in livestock or dairy production which may be applicable to veterinarians but should be claimed only with caution by them.

A veterinarian engaged in retail sales, in addition to furnishing professional services, must account for sales tax on the gross receipts from such sales.

This rule is intended to implement Iowa Code sections 422.42(3) and 422.43.

701—18.24(422,423) Hospitals, infirmaries and sanitariums. Hospitals, infirmaries, sanitariums, and like institutions are engaged primarily in rendering services. These facilities shall not be subject to tax on their purchases of items of tangible personal property exempt under 701—Chapter 20 when the items would be exempt if purchased by the individual and if the item is used substantially for the tax-exempt purpose. See rule 18.59(422,423) for an exemption applicable to sales of goods and furnishing of services on and after July 1, 1998, to a nonprofit hospital.

Hospitals, infirmaries, and sanitariums may be the purchasers for use or consumption of tangible personal property used or consumed in furnishing services. *Modern Dairy Co. v. Department of Revenue*, 413 Ill. 55, 108 N.E.2d 8 (1952). However, tangible personal property can be purchased for resale by these facilities and, if purchased for resale, is exempt from tax on the purchases. *Burrows Co. v. Hollingsworth*, 415 Ill. 202, 112 N.E.2d 706 (1953); *Fefferman v. Marohn*, 408 Ill. 542, 97 N.E.2d 785 (1951). Property is purchased for resale if the conditions in subrule 18.31(1) are applicable. See also 701—subrule 15.3(2) with respect to resale exemption certificates.

Depending upon the circumstances, a nonprofit facility may be a charitable institution or organization; a profit facility is not. *Northwest Community Hospital v. Board of Review of City of Des Moines*, 229 N.W.2d 738 (Iowa 1975); *Readlyn Hospital v. Hoth*, 223 Iowa 341, 272 N.W. 90 (1937). Sales by these nonprofit facilities would be exempt from tax if the requirements of Iowa Code section 422.45(3) are met. See rule 701—17.1(422,423).

This rule is intended to implement Iowa Code section 422.45 as amended by 1998 Iowa Acts, House File 2513, and chapter 423.

701—18.25(422,423) Warranties and maintenance contracts.

18.25(1) In general—definitions. “Mandatory warranty.” A warranty is mandatory within the meaning of this regulation when the buyer, as a condition of the sale, is required to purchase the warranty or guaranty contract from the seller. “Optional warranty.” A warranty is optional within the meaning of this regulation when the buyer is not required to purchase the warranty or guaranty contract from the seller.

18.25(2) Mandatory warranties. When the sale of tangible personal property or services includes the furnishing or replacement of parts or materials which are pursuant to the guaranty provisions of the sales contract, a mandatory warranty exists. If the property subject to the warranty is sold at retail, and

the measure of the tax includes any amount charged for the guaranty or warranty, whether or not such amount is purported to be separately stated from the purchase price, the sale of replacement parts and materials to the seller furnishing them thereunder is a sale for resale and not taxable. Labor performed under a mandatory warranty which is in connection with an enumerated taxable service is also exempt from tax.

18.25(3) Optional warranties. For periods after June 30, 1981.

a. The sale of optional service or warranty contracts which provide for the furnishing of labor and materials and require the furnishing of any taxable service enumerated under Iowa Code section 422.43 is considered a sale of tangible personal property the gross receipts from which are subject to tax at the time of sale except as described below.

b. On and after July 1, 1995, the sale of a residential service contract regulated under Iowa Code chapter 523C is not considered to be the sale of tangible personal property, and gross receipts from the sales of these service contracts are no longer subject to tax, and the gross receipts from taxable services performed for the providers of residential service contracts are now subject to tax. See the examples below for more detailed explanation. A “residential service contract” is defined in Iowa Code subsection 523C.1(8) to be: a contract or agreement between a residential customer and a service company which undertakes, for a predetermined fee and for a specified period of time, to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems of residential property containing not more than four dwelling units.

EXAMPLE A. John Jones purchases a residential service contract for \$3,000 on July 1, 1994. He pays \$150 of Iowa state sales tax. On December 1, 1994, his furnace malfunctions. The service company which sold Mr. Jones the contract pays Smith Furnace Repair \$700 to fix the furnace. No sales tax is due on the \$700 charge.

EXAMPLE B. Bob Jones purchases a residential service contract for \$3,000 on July 1, 1995. No sales tax is owing or paid. On December 1, 1995, his furnace becomes inoperable. The service company which sold Mr. Jones the contract pays Smith Furnace Repair \$900 to fix Mr. Jones’ furnace. Sales tax of \$45 is due based on the \$900.

c. On and after July 1, 1998, if an optional service or warranty contract is a computer software maintenance or support service contract and the contract provides for the furnishing of technical support services only and not for the furnishing of any materials, then no tax is imposed on the furnishing of those services under this subrule. If a computer software maintenance or support service contract provides for the performance of nontaxable services and the taxable transfer of tangible personal property, and no separate fee is stated for either the performance of the service or the transfer of the property, then state sales tax of 5 percent shall be imposed on 50 percent of the gross receipts from the sale of the contract. If a charge for the performance of the nontaxable service is separately stated, see subrule 18.25(5) below.

18.25(4) A preventive maintenance contract is a contract which requires only the visual inspection of equipment and no repair is or shall be included. The gross receipts from the sale of a preventive maintenance contract is not subject to tax.

18.25(5) Additional charges for parts and labor furnished in addition to that covered by a warranty or maintenance contract which are for enumerated taxable services shall be subject to tax. Only parts and not labor will be subject to tax where a nontaxable service is performed if the labor charge is separately stated.

This rule is intended to implement Iowa Code sections 422.42 and 423.2 and Iowa Code Supplement section 422.43 as amended by 1998 Iowa Acts, Senate File 2288.

701—18.26(422) Service charge and gratuity. When the purchase of any food, beverage or meals automatically and invariably results in the inclusion of a mandatory service charge to the total price for such food, beverage or meal, the amounts so included shall be subject to tax. The term “service charge” means either a fixed percentage of the total price of or a charge for food, beverage or meal.

The mandatory service charge shall be considered: (1) a required part of a transaction arising from a taxable sale and a contractual obligation of a purchaser to pay to a vendor arising directly from and as

a condition of the making of the sale and (2) a fixed labor cost included in the price for food, beverage or meal even though such charge is separately stated from the charge for the food, beverage or meal.

When a gratuity is voluntarily given for food, beverage or meal it shall be considered a tip and not subject to tax.

Cohen v. Playboy Club International, Inc., 19 Ill. App. 3d 215, 311 N.E.2d 336; *Baltimore Country Club, Inc. v. Comptroller of Treasury*, 272 Md. 65, 321 A.2d 308.

This rule is intended to implement Iowa Code section 422.43.

701—18.27(422) Advertising agencies, commercial artists, and designers.

18.27(1) Nontaxable services. Tax does not apply to charges by advertising agencies, commercial artists, or designers for services rendered that do not represent services that are a part of a sale of tangible personal property, or a labor or service cost in the production of tangible personal property. Examples of such nontaxable services are: writing original manuscripts and news releases; writing copy for use in newspapers, magazines, or other advertising, or to be broadcast on television or radio, compiling statistical and other information; placing or arranging for the placing of advertising in media, such as newspapers, magazines, or other publications; billboards and other facilities used in public transportation; and delivering or causing the delivery of brochures, pamphlets, cards, and similar items. Charges for such items as supervision, consultation, research, postage, express, transportation and travel expense, if involved in the rendering of such services, are likewise not taxable.

18.27(2) Agency fee or commission. When an amount billed as an agency “fee,” “service charge,” or “commission” represents a charge or part of the charge for any of the nontaxable services described under 18.27(1), the amount so billed is not taxable. Such charge by an advertising agency will be considered to be made for nontaxable services.

18.27(3) Items taxable. The tax applies to the entire amount charged to clients for items of tangible personal property such as drawings, paintings, designs, photographs, lettering, assemblies and printed matter. This includes the cost of typography and reproduction proofs when the latter is used as part of a paste-up, “mechanical” or assembly. Whether the items of property are used for reproduction or display purposes is immaterial.

18.27(4) Preliminary art. “Preliminary art” as used herein means roughs, visualizations, comprehensives and layouts prepared for acceptance by clients before a contract is entered into or approval is given for finished art. (“Finished art” as used herein means the final art used for actual reproduction by photo-mechanical or other processes.) Tax does not apply to separate charges for preliminary art, except where the preliminary art becomes physically incorporated into the finished art as for example, when the finished art is made by inking directly over a pencil sketch or drawing, or the approved layout is used as camera copy for reproduction.

The charge for preliminary art must be billed separately to the client, either on a separate billing or separately charged for on the billing for the finished art. It must be clearly identified on the billing as preliminary art, of one or more of the types mentioned in the preceding paragraph. Proof of ordering or producing the preliminary art prior to date of contract or approval for finished art shall be evidenced by purchase orders of the buyer, or by work orders or other records of the seller.

The following situations are examples of when the sale of “finished art” is taxable:

a. Finished art which is sold to customers to be used for advertising purposes in newspapers, magazines or the like. After the advertiser contracts with the ad agency for the development of an advertising message or theme, the agency devises ideas (preliminary art) and produces the finished art. The finished art is then delivered to the advertiser or to an agent of the advertiser such as a printer or publisher who is under contract with the advertiser to publish the ad.

b. Finished art which is sold to customers, or their agents (e.g., printers), for use in producing printed material. The charge for finished art is taxable even though the art work may later be returned to the ad agency by the purchaser or the printer or used by the customer or the customer’s agent to produce a nontaxable item. Since the finished art is not a part of the printed materials, the ad agency’s customer is consuming the material and not buying it for resale, or using it in an exempt manner.

c. Finished art which is used to produce other tangible personal property sold by the ad agency such as letterhead stationery and business cards. The charge for such art is taxable as part of the selling price for such stationery or business cards. This is true whether or not the agency separately itemizes the charge for such stationery or business cards.

18.27(5) *Items purchased by agency, artist or designer.* An advertising agency, artist, or designer is the consumer of tangible personal property used in the operation of its business, such as stationery, ink, paint, tools, drawing tables, T-squares, pens, pencils, and other office supplies. Tax applies to the sale of such property to the agency, artist, or designer. Tax also applies where the agency, artist or designer is the consumer of taxable services.

The agency, artist, or designer is the seller of, and may purchase for resale, any item resold before use, or that becomes physically an ingredient or component part of tangible personal property sold, as, for example, illustration board, paint, ink, rubber cement, flap paper, wrapping paper, photographs, photostats, or art purchased from other artists. Tax also applies where the agency, artist, or designer is the seller at retail of taxable services.

In the event that an agency, artist, or designer is both a consumer and a retailer of such items of tangible personal property as noted in this subsection, such agency, artist or designer should:

a. Purchase such items without tax liability if the majority of the items are sold at retail and remit the tax at the time of resale or at the time such items are consumed in the operation of the business.

b. Pay tax to suppliers at the time of purchase if the majority of the items will be consumed in the operation of the business and deduct the original cost of any such items subsequently sold at retail when reporting tax on their returns.

18.27(6) *Construction.* Nothing contained in this rule shall be construed to provide for an exemption from tax for services expressly taxable in rules 701—26.17(422) and 26.39(422).

18.27(7) *Advertising agencies, commercial artists and designers as agent of client or as a nonagent.*

a. In general. A true agent relationship depends upon the facts with respect to each transaction. An agent is one who represents another, called the principal, in dealings with third persons. Advertising agencies, commercial artists, and designers may act as agents on behalf of their clients in dealing with third persons or they may act on their own behalf. To the extent advertising agencies, artists and designers act as agents of their clients in acquiring tangible personal property, they are neither purchasers of the property with respect to the supplier nor sellers of the property with respect to their principals.

b. When advertising agencies, commercial artists, and designers act as agents of their clients in purchasing property for their clients, the tax applies to the gross receipts from the sale of such property to the advertising agencies, commercial artists, and designers. Unless such advertising agencies, commercial artists and designers act as true agents, they will be regarded as the retailers of tangible personal property furnished to their clients and the tax will apply to the total amount received for such property. Further, nothing in this rule should be construed to be in variance with the opinion of the Iowa Supreme Court in *Rowe vs. Iowa State Tax Commission*, 249 Iowa 1207, 91 N.W.2d 548 (1958).

c. To establish that a particular acquisition is made in the capacity of an agent for a client, advertising agencies, commercial artists, and designers (collectively herein referred to as agency) shall act as follows:

1. The agency must clearly disclose to the supplier the name of the client for whom the agency is acting as an agent.

2. The agency must obtain, prior to the acquisition, and retain written evidence of agent status with the client.

3. The price billed to the client, exclusive of any agency fee, must be the same as the amount paid to the supplier. The agency may make no use of the property for its own account, such as commingling the property of a client with another, and the reimbursement for the property should be separately invoiced or shown separately on the invoice to the client.

d. Some charges may represent reimbursement for tangible personal property acquired by the agency as agents for its clients and compensation for performing of agency services related thereto. When an advertising agency, commercial artist, or designer establishes that it has acquired tangible personal property as agents for its clients, tax does not apply to the charge made by the agency to its client for

reimbursement charges by a supplier or to the charges made for the performance of the agency's services directly related to the acquisition of personal property.

e. Advertising agencies, commercial artists, and designers acting as agents shall not issue resale certificates to suppliers.

f. Advertising agencies, commercial artists, and designers act as retailers of all items of tangible personal property produced or fabricated by their own employees when they sell to their clients. Advertising agencies, commercial artists, and designers are not agents of their clients with respect to the acquisition of materials incorporated into items of tangible personal property prepared by their employees and sold at retail to their clients.

18.27(8) Scope. The scope of this rule is not confined simply to advertising agencies, commercial artists and designers, but also applies to all other businesses whose activities would bring them within the scope of this rule (e.g., printers).

This rule is intended to implement Iowa Code sections 422.43 and 423.2.

701—18.28(422,423) Casual sales.

18.28(1) Casual sales by persons not retailers or by retailers outside the regular course of business. Casual sales are exempt from the Iowa sales and use taxes except for the casual sale of vehicles subject to registration, and vehicles subject only to the issuance of a certificate of title. On and after July 1, 1988, the casual sale of aircraft is also taxable. In order for a casual sale to qualify for exemption under this subrule, two conditions must be present: (1) the sale of tangible personal property or taxable services must be of a nonrecurring nature, and (2) the seller, at the time of the sale, must not be engaged for profit in the business of selling tangible goods or services taxed under Iowa Code section 422.43 or, if so engaged, the sale must be outside the regular course of the seller's business (Order of State Board of Tax Review, Martin Development Corporation, Docket No. 136, December 1, 1976, incorporating by reference Order of Department of Revenue Hearing Officer in Docket No. 75-28-6A-A, July 9, 1976). See subrule 18.28(2) for an explanation of the casual sale exemption applicable to the liquidation of a trade or business.

If either of the conditions above are lacking, no casual sale occurs. Moreover, prior to July 1, 1985, the casual sale exemption was limited to sales of tangible personal property, and casual enumerated taxable services did not qualify for the exemption. *KTVO, Inc. v. Bair*, Equity No. 385 Linn County District Court, September 5, 1975.

For the purposes of this subrule, the word "aircraft" refers to any contrivance now known or hereafter invented, which is designed or used for navigation of or flight in the air, for the purpose of transporting persons, property, or both or for crop dusting, aerial surveillance, recreational flying, or for providing some other service. By way of nonexclusive example, balloons, gliders, helicopters, and "ultra lights" are aircraft. Also included within the meaning of the word "aircraft" is any craft registered under Iowa Code section 328.20 or any successor statute thereto.

Sales of capital assets such as equipment, machinery, and furnishings which are not sold as inventory shall be deemed outside the regular course of business (including sales of capital assets during a retailer's liquidation) and the casual sales exemption shall apply as long as such sales are nonrecurring. This will include transactions exempted from state and federal income tax under Section 351 of the Internal Revenue Code.

Two separate selling events outside the regular course of business within a 12-month period shall be considered nonrecurring. Three such separate selling events within a 12-month period shall be considered as recurring. Tax shall only apply commencing with the third separate selling event. However, in the event that a sale event occurs consistently over a span of years, such sale is recurring and not casual, even though only one sales event occurs each year. *Des Moines Police Department v. Bair*, Equity No. CE3-1591, Polk County District Court, November 1, 1976.

EXAMPLE: Corporation A sells the company copy machine at retail to B. At the time of this sale, Corporation A is engaged in the business for profit of selling clothes at retail. Assuming that the sale of the copy machine constitutes a sale of a nonrecurring nature, there is a casual sale because the sale is outside the regular course of Corporation A's business.

EXAMPLE: Corporation C is engaged in the business of lending money secured by collateral. In the course of such business, Corporation C must repossess some collateral and sell it at retail for purposes of payment of loans. Such sales recur from time to time. Notwithstanding that Corporation C is presumably not engaged in the business of selling tangible goods or services for a profit, since the sales are recurring, there is no casual sale. *S & M Finance Co., Fort Dodge v. Iowa State Tax Commission*, 1968, Iowa 162 N.W.2d 505.

EXAMPLE: F, a farmer, does not sell tangible personal property at retail or engage in the performance of any taxable services. F liquidates the farming business and hires a professional auctioneer to auction off many items of tangible personal property. Assuming this liquidation event is casual, all items sold by the auctioneer at retail are casual sales notwithstanding that many different sales to numerous different buyers may occur. See rule 18.8(422).

EXAMPLE: H, an insurance agency, holds a semiannual event to sell its used office furniture. Even though H does not regularly sell tangible personal property at retail, the casual sale exemption does not apply because the selling events are recurring. *Des Moines Police Department v. Bair*, Equity No. CE3-1591, Polk County District Court, November 1, 1976.

EXAMPLE: I, a corporation, has one sales event every year whereby it auctions off capital assets which it has no use for or desires to replace. This event has been a planned function of I and is conducted regularly and consistently over a span of years. Even though this sale event occurs only once a year, it is of a recurring nature because of the pattern of repetitiveness present and, therefore, the casual sale exemption would not apply, regardless of the number of items sold at such sale event each year.

EXAMPLE: J, a corporation engaged in the sale for resale of tangible personal property, sells three capital assets used in J's trade or business consisting of a copy machine, a desk, and a computer. Each sale is made to different buyers and is unrelated to the other sales. The three sales occur in January, June, and October of the same year. The sale made in October consists of a desk. J has not established a pattern of recurring sales of capital assets prior to aforementioned sales of capital assets. Under these circumstances, the sale of the desk is not a casual sale, but the sales of the copy machine and the computer are casual and exempt.

EXAMPLE: K, a corporation, is primarily engaged in the business of road construction. From time to time, it sells used capital assets and scrap materials reclaimed from its road construction work to individuals and businesses. It does not advertise itself as a retailer of these assets and materials but sells them as a matter of courtesy to persons who cannot purchase them elsewhere. After 42 years of operation, it decides to liquidate. Pursuant to that decision, K employs two auctioneers to sell its capital assets and ceases operation after its assets are sold. K had only one capital asset sale during the 12 months immediately preceding each liquidation auction sale. The auction sales are exempt casual sales under this subrule (1) because they are nonrecurring, and (2) because K is not a retailer of the capital assets sold during its liquidation. See *Holland Bros. Construction Co., Inc. v. Iowa State Board of Tax Review*, 611 N.W.2d 495 (Iowa 2000).

EXAMPLE: L, a sole proprietorship, engaged in selling automobile parts at retail, incorporated. The assets of L are sold to the new corporation in exchange for stock and the new corporation now engages in selling automobile parts at retail. The casual sale exemption would apply, but only because of the exemption set out in subrule 18.28(2) *infra*, since the transfer involves a liquidation of L's business and the sale of L's inventory to another person (the corporation) which will continue to engage in a similar trade or business.

The above examples are not the only ones pertaining to the questions of whether a casual sale did or did not occur. However, because of the myriad of factual situations which can and do exist, it is not possible to formulate more detailed rules on this subject matter.

18.28(2) *Special rules for casual sales involving the liquidation of a trade or business.* When retailers sell all or substantially all of the tangible personal property held or used in the course of the trade or business for which retailers are required to hold a sales tax permit, the casual sale exemption will apply to exempt those sales only when the following circumstances exist: (1) the trade or business must be transferred to another person, and (2) the transferee must engage in a similar trade or business. The trade or business transferred refers to the place where the business is located since each taxable retail

business must have a sales tax permit at each location. For purposes of this casual sale circumstance, it is irrelevant whether the retailer actually has a sales tax permit or not; rather, the relevant circumstance is that the retailer was required to have a sales tax permit. See *Holland Bros. Construction Co., Inc. v. Iowa State Board of Tax Review*, 611 N.W.2d 495 (Iowa 2000). One effect of this is that a retailer who is closing as opposed to transferring a business and is selling inventory in the process of this closing is not entitled to claim the casual sale exemption under this subrule, but see subrule 18.28(1), and the resale exemption is always potentially applicable to sales of inventory. See the examples below for further explanation.

EXAMPLE: L, a hardware store, desires to liquidate the business. L had been selling tangible personal property at retail and was required to have an Iowa retail sales tax permit. L hires a professional auctioneer and all items of inventory, equipment, and fixtures are sold to various purchasers. These items consist of all or substantially all of the tangible personal property held or used by L in the course of the business for which a sales tax permit was required to be held. L, however, does not transfer the trade or business to anyone else. Under these circumstances, the casual sales exemption does not apply to the sale of the inventory, but see subrule 18.28(1) for criteria which determine whether the casual sales exemption applies to the equipment and fixtures.

EXAMPLE: The facts are the same as those in the previous example, except that L is liquidating its business because it attempted to build a new store and its entire inventory was destroyed by fire while in storage. An auctioneer sells L's equipment and trade fixtures to various purchasers. The auctioneer's sale of the equipment and trade fixtures is an exempt casual sale of the type described in subrule 18.28(1) because (1) it is nonrecurring, and (2) it is outside the usual course of L's business. See *Holland Bros. Construction Co., Inc.*, supra.

EXAMPLE: M, a sole proprietorship, incorporated. The assets of M are sold to the new corporation for stock. The new corporation engaged in a similar business. The casual sale exemption would apply.

EXAMPLE: N, an oil company, sells all or substantially all of the tangible personal property of ten company-owned service stations which were held or used in the course of its business, for which N was required to hold a sales tax permit, by bulk sales or otherwise. The sales were made to O, P, and Q and occurred at different times during the same year, each sale being unrelated. N was required to have a sales tax permit for each service station. N transferred its trade or business (each service station) to O, P, and Q, each of whom will engage in the same business N did, i.e., operation of service stations. Even though under these circumstances, the sales by N are recurring, the casual sales exemption would apply since each trade or business was transferred to another person who did engage in a similar trade or business.

EXAMPLE: R, an operator of a restaurant, auctions off to various purchasers who are not engaged in the restaurant business all or substantially all of the tangible personal property held or used in the business for which R was required to hold a retail sales tax permit. R transfers the trade or business to S who then operates a restaurant at the same location R did. Even if S did not purchase any of the tangible personal property, under these circumstances, the casual sales exemption applies. The tangible personal property held or used in the trade or business need not be sold to the same person to whom the trade or business is sold for the exemption to apply.

EXAMPLE: T, a restaurant, sells all of its tangible personal property held or used in the course of its business for which it was required to hold a sales tax permit to U. T also sells its trade or business to U. U engages in the business of operation of a dance hall and does not continue to operate the restaurant. This subrule's casual sales exemption will not apply, but see subrule 18.28(1) for the criteria of a casual sale exemption which could apply.

The above examples are not the only ones pertaining to the questions of whether a casual sale did or did not occur. However, because of the myriad of factual situations which can and do exist, it is not possible to formulate more detailed rules on this subject matter.

18.28(3) Casual sales of services. Special rule for services rendered, furnished, or performed on or after July 1, 1985. The "casual sale" of an enumerated service has occurred if the following circumstances exist:

- a. The service was rendered, furnished, or performed on or after July 1, 1985; and

b. The service was rendered, furnished, or performed on a nonrecurring basis by a seller who, at the time of the sale of the service, is not engaged for profit in the business of selling tangible goods or services taxed under Iowa Code section 422.43, or, if so engaged, the sale was outside the regular course of the seller's business; or

c. The sales of all, or substantially all of the services held or used by a retailer in the course of the retailer's trade or business for which the retailer is required to hold a sales tax permit, if the retailer sells or otherwise transfers the trade or business to another person who engages in a similar trade or business.

EXAMPLE: V ordinarily engages in janitorial and building maintenance or cleaning which are taxable services; see rule 701—26.60(422). Once, as a favor to customer W, V cut customer W's lawn and otherwise performed the taxable service of "lawn care" for customer W. Since this performance of lawn care was not "within V's regular course of business" and was not "recurring," gross receipts from the lawn care are not subject to tax.

EXAMPLE: Corporation X rents a piece of equipment from Y. Y does not otherwise rent equipment and does not engage in the business for profit of selling tangible goods or taxable enumerated services. A casual sale qualifying for the exemption exists.

This rule is intended to implement Iowa Code sections 422.42(12), 422.45(6) and 423.4.

701—18.29(422,423) Processing, a definition of the word, its beginning and completion characterized with specific examples of processing.

18.29(1) Processing—a definition. For the purpose of these rules, "processing" means an operation or a series of operations whereby tangible personal property is subjected to some special treatment by artificial or natural means which changes its form, context, or condition, and results in marketable tangible personal property. These operations are commonly associated with fabricating, compounding, germinating, or manufacturing. *Linwood Stone Products Co. v. State Department of Revenue*, 175 N.W.2d 393 (Iowa 1970).

18.29(2) The beginning of processing. Processing begins when the "form, context, or condition" of tangible personal property is changed with the intent of eventually transforming the property into a saleable finished product. The severance of raw material from real estate is not processing, even if this severance results in a change in the form, context, or condition of the real estate. *Linwood Stone Products Co. v. State Department of Revenue*, 175 N. W.2d 393 (Iowa 1970). Furthermore, transportation of raw material after it is severed from real estate but prior to the time the initial change in the form, context, or condition of the raw material occurs is not processing. *Southern Sioux County Rural Water System, Inc. v. Iowa Department of Revenue*, 383 N.W.2d 585 (Iowa 1986).

18.29(3) The completion of processing. Processing ends when the property being processed is in the form in which it is ultimately intended to be sold at retail, *Hy-Vee Food Stores v. Iowa Department of Revenue*, 379 N.W.2d 37 (Iowa App. 1985). The storage or transport of property after that property is transformed into a finished product is not a part of processing.

18.29(4) Examples of when processing begins and ends. The following examples are intended to clarify but not to contradict the explanation of processing set out in subrules 18.29(2) and 18.29(3).

EXAMPLE A: A company blasts limestone from the ground, bulldozers pick the limestone up and put it in trucks; these trucks transport the limestone to a crusher some distance from the quarry site. The first change in the "form" or "condition" of the limestone, while it is tangible personal property, occurs when the stone is crushed in the crusher. The blasting of the stone from the ground and its transport to the crusher would be acts preparatory to and not a part of processing. Thus, fuel used in the bulldozers and transport trucks would not be fuel used in processing, *Linwood Stone Products*, supra.

EXAMPLE B: Pumps remove water from underground wells and pump that water through pipes to a water treatment plant. At the treatment plant, the water passes initially through an aeration system which adds oxygen to it. At other points in the plant, potassium and chlorine are added to the water and iron is removed. After these acts are performed, clean, drinkable water exists. The first change, however, in the condition of the water occurs when it passes through the aeration system and oxygen is added to it. The withdrawal of the water from the ground and its transport to the aeration system would not be a part of processing. Thus, electricity used by the pumps which pump the water to the aeration system would

not be used in processing. However, by way of contrast, electricity used to transport the water between, for example, the aeration system and the point where potassium is added to the water would be used in processing. *Southern Sioux Rural Water System, Inc.*, supra.

EXAMPLE C: Water is processed in a treatment plant. The last act at the plant necessary to render the water drinkable or a “finished product” is the addition of chlorine. After the addition of chlorine, the water is pumped first into wells and later into water towers where it is held for distribution. The pumping of this drinkable water from the point where the chlorine is added to the wells and the tower is not a part of processing because processing of the water ended with the addition of the chlorine; thus, electricity used in these pumps is not electricity used in processing. *Southern Sioux County Rural Water System, Inc.*, supra.

18.29(5) Integral part of the production of the product test. Certain activities may be exempt as part of processing if those activities are very closely interconnected with, or an integral part of, the operation of the processing equipment while processing is occurring. *Southern Sioux Rural Water System, Inc.*, supra. Merely because an activity is vital or essential to a processing operation does not make that activity exempt as part of processing unless the activity itself is closely interconnected with, or an integral part of, the operation of the processing equipment while processing is occurring. *Mississippi Valley Milk Producers Ass’n v. Iowa Dept. of Revenue*, 387 N.W.2d 611 (Iowa App. 1986). See the nonexclusive example below.

A manufactures nails. In A’s factory is a machine which draws steel into long rods the width of whatever nail A may wish to manufacture. After this machine draws the steel into the desired-size rods, the rods are moved to a second machine by a conveyor belt. This second machine cuts the rods into the length of nail which A desires. A second conveyor belt then transports these cut rods to a third machine which sharpens one end of the rod to a point and puts a “nail head” on the other end of the rod. The activities of the three machines are clearly processing, in that they are activities which change the form, context or condition of raw material, and as a result of those activities, marketable tangible personal property or a finished product is created. The two conveyor belts move the partially finished nails from one piece of processing equipment to another while processing is occurring. Since the activities of the conveyors are very closely interconnected with and an integral part of the operation of the various pieces of processing equipment while processing is occurring, the conveyor belts are involved in processing as well.

18.29(6) Other specific examples of processing. The Iowa Supreme Court has also stated that the following activities are processing: manufacturing ice, refrigerating cheese to age it from “green” to edible, refrigerating eggs to change their flavor, pasteurizing and subsequent refrigeration of milk, “hard” freezing of meat and butter for aging, canning vegetables and cooking foodstuffs; *Fischer Artificial Ice & Cold Storage Co. v. Iowa State Tax Commission*, 248 Iowa 497, 81 N.W.2d 437 (1957); and, *Mississippi Valley Milk Producers v. Iowa Dept. of Revenue and Finance*, 387 N.W.2d 611 (Ia. App. 1986), also crushing of “flat rock” limestone and treating limestone in kilns. *Linwood Stone Products Co. v. State Dept. of Revenue*, 175 N.W.2d 393 (Iowa 1970). See 701—subrule 17.3(2) for an expanded definition of processing with regard to food manufacturing.

18.29(7) Other department rules concerned with processing. Various sections of the Iowa Code set out activities that are defined by statute to be “processing.” The rules interpreting these statutes for the purposes of sales and use tax law are the following:

a. 701—15.3(422,423) Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers.

b. 701—17.2(422) Fuel used in processing—when exempt.

c. 701—17.3(422,423) Processing exemptions.

d. 701—17.9(422,423) Sales of breeding livestock, fowl, and certain other property used in agricultural production. See 701—subrules 17.9(4), 17.9(5), 17.9(6), and 17.9(7) for processing exemptions.

e. 701—17.14(422,423) Chemicals, solvents, sorbents, or reagents used in processing.

f. 701—18.3(422,423) Chemical compounds used to treat water.

g. 701—18.45(422,423) Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997.

h. 701—18.58(422,423) Sales or rentals of machinery, equipment, and computers and sales of fuel and electricity to manufacturers and sales or rentals of computers to commercial enterprises for periods on and after July 1, 1997, but before July 1, 2016.

i. 701—26.2(422) Enumerated services exempt. See 701—subrule 26.2(2) for the processing exemption.

j. 701—28.2(423) Processing of property defined.

k. 701—33.3(423) Fuel consumed in creating power, heat, or steam for processing or generating electric current.

l. 701—33.7(423) Property used to manufacture certain vehicles to be leased.

m. For property sold on or after July 1, 2016, computers, machinery, equipment, replacement parts, and supplies used for an exempt purpose under Iowa Code section 423.3(47). See rules 701—230.14(423) to 701—230.22(423).

[ARC 2349C, IAB 1/6/16, effective 2/10/16; see Rescission note at end of chapter; ARC 2768C, IAB 10/12/16, effective 11/16/16]

701—18.30(422) Taxation of American Indians.

18.30(1) Definitions.

“*American Indians*” means all persons of Indian descent who are members of any recognized tribe.

“*Settlement*” means all lands within the boundaries of the Mesquakie Indian settlement located in Tama County, Iowa and any other recognized Indian settlement or reservation within the boundaries of the state of Iowa.

18.30(2) Retail sales tax—tangible personal property. Retail sales of tangible personal property made on a recognized settlement or reservation to Indians who are members of the tribe located on that settlement or reservation, where delivery occurs on the reservation, are exempt from tax (*Bryan v. Itasca County*, 426 U.S. 373, 376-77 (1976); *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 475-81 (1976)). Retail sales of tangible personal property made on a recognized settlement or reservation to Indians where delivery occurs off the reservation are subject to tax. Retail sales of tangible personal property made to non-Indians on a recognized settlement or reservation are subject to tax regardless of where the delivery occurs. Sales made to non-Indians are taxable even though the seller may be a member of a recognized settlement or reservation.

18.30(3) Retail sales tax—services. Sales of enumerated taxable services and sales made by municipal corporations furnishing gas, electricity, water, heat, or communication services to Indians who are members of the tribe located on the recognized settlement or reservation where delivery of the service occurs are exempt from tax (*Bryan v. Itasca County*, 426 U.S. 373, 376-77 (1976); *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 475-81 (1976)). Sales of enumerated taxable services or sales made by municipal corporations furnishing gas, electricity, water, heat, or communication services to Indians where delivery of the services occurs off a recognized settlement or reservation are subject to tax.

18.30(4) Off-reservation purchases. Purchases made by Indians off a recognized settlement or reservation are subject to tax if delivery occurs off the reservation. Purchases made by Indians off a recognized settlement or reservation are not subject to tax if delivery is made on the reservation to Indians who are members of the tribe located on that reservation.

See rule 701—33.5(423) for the taxation of tangible personal property and services where the state use tax may be applicable.

This rule is intended to implement Iowa Code sections 422.42, 422.43, and 422.45(1).

701—18.31(422,423) Tangible personal property purchased by one who is engaged in the performance of a service.

18.31(1) In general. (Effective July 1, 1990)

a. On and after July 1, 1990, tangible personal property purchased by one who is engaged in the performance of a service is purchased for resale and not subject to tax if (1) the provider and user of

the service intend that a sale of the property will occur, and (2) the property is transferred to the user of the service in connection with the performance of the service in a form or quantity capable of a fixed or definite price value, and (3) the sale is evidenced by a separate charge for the identifiable piece or quantity of property.

b. Prior to July 1, 1990, in those circumstances in which tangible personal property is purchased by one who is engaged in the performance of a service and the property is transferred to the customer in conjunction with a performance of the service in a form or quantity which is capable of any fixed or definite price value, but the actual sale of the property is not indicated by a separate charge for the identifiable item, the burden of proving that the property was purchased for resale by one engaged in the performance of a service and not subject to tax at the time of purchase is upon the person engaged in the performance of a service who asserts this.

c. Tangible personal property which is not sold in the manner set forth in “*a*” or “*b*” above is not purchased for resale and thus is subject to tax at the time of purchase by one engaged in the performance of a service. Such tangible personal property is considered to be consumed by the purchaser who is engaged in the performance of a service and the person performing the service shall pay tax upon the sale at the time of purchase.

EXAMPLE: An investment counselor purchases envelopes. These envelopes are used to send out monthly reports to the investment counselor’s clients regarding their accounts. Tax is due at the time the investment counselor purchases the envelopes if the clients are not billed for these items. Each envelope is transferred to a client in a form or quantity which is capable of a fixed or definite price value. However, there must also be an actual sale to the client (customer) of an item of personal property in order that there be a “resale” of the item.

An automobile repair shop purchases solvents which are used in cleaning automobile parts and thus in performing its automobile repair service. Tax is due at the time the automobile repair shop purchases the solvent since the solvents are not sold to the customer and, in this case, the item is not transferred to a customer in a form or quantity which is capable of a fixed or definite price value. Thus, the solvent is deemed consumed by the purchaser engaged in the performance of the service.

EXAMPLE: A retailer purchases television tubes tax-free where the retailer makes a separate charge for the tube to the customer and since the tube is transferred to the customer in a form or quantity capable of a fixed or definite price value.

EXAMPLE: A beauty or barber shop purchases shampoo and other items to be used in the performance of its service. Tax is due at the time the beauty or barber shop purchases such items from its supplier, where the customers of the beauty or barber shop are not separately billed for the item, and because it is not transferred to the customer in a form or quantity capable of a fixed or definite price value, it is being consumed by the beauty or barber shop.

EXAMPLE: A car wash purchases water, electricity, or gas used in the washing of a car. The car wash would be the consumer of the water, electricity, or gas and tax is due at the time of purchase. The items purchased by the car wash are not transferred to the customer in a form or quantity capable of a fixed or definite price value, and the customer is not billed for the item.

EXAMPLE: An accounting firm purchases plastic binders which are used to cover the reports issued to its customers. These binders would be subject to tax at the time of purchase by the firm where the customer of the firm is not billed for the item, there being no sale to the customer in such a case.

EXAMPLE: A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers who provide the locker with the meat. These materials would be subject to tax at the time of purchase by the meat locker because they are not sold to the customer in a form or quantity capable of a fixed or definite price value.

EXAMPLE: A jeweler purchases materials such as main springs and crystals to be used in the performance of a service. These items are purchased by the jeweler for resale where they are transferred to the customer in a form or quantity capable of a fixed or definite price value and each item is actually sold to the customer as evidenced by a separate charge therefor.

EXAMPLE: A lawn care service applies fertilizer, herbicides, and pesticides to its customers’ lawns. The following are examples of invoices to customers which are suitable to indicate a lawn care service’s

purchase of the fertilizer, herbicides, and pesticides for resale to those customers: “Chemicals...31 Gal...\$60”; “Fertilizer...50 lbs....\$100”; and “Materials applied to lawn...4 bushel...\$40”. The following are examples of information placed upon an invoice which would not indicate a purchase for resale to the customers invoiced: “Fifty percent of the charge for this service is for materials placed on a lawn,” or “Lawn chemicals...\$30” or “Fifty pounds of fertilizer was applied to this lawn.”

18.31(2) *Purchases made by automobile body shops or garages with body shops (effective October 1, 1980).*

Tangible personal property purchased by body shops can be purchased for resale provided both of the following conditions are met:

1. The property purchased for resale is actually transferred to the body shop’s customer by becoming an ingredient or component part of the repair work. See Iowa Code section 422.42(2) and *Cedar Valley Leasing Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979).

2. The property purchased for resale is itemized as a separate item on the invoice to the body shop’s customer and is transferred to the customer in a form or quantity capable of a fixed or definite price value.

If either of the above two events is missing, there is no purchase for resale and the body shop is deemed the consumer of the item purchased.

When body shops purchase items which will be resold (see list of items in this rule) in the course of the repair activity, the vendors selling to the body shops are encouraged to accept a valid resale certificate at the time of purchase. See rule 701—15.3(422,423). Failure of the vendor to accept a valid resale certificate may subject that vendor to sales tax liability since the burden of proof would be on the vendor that a sale was made for resale. If the vendor cannot meet that burden, the vendor will be liable for the sales tax. Such burden is not met merely by a showing that the purchaser had obtained from the department an Iowa retail sales tax or retail use tax permit.

For insurance purposes, body shops are reimbursed by insurance companies for “materials” which such shops consume in rendering repair services. Some of the materials are transferred to the recipients of the repair services and some are not. Of those so transferred, such transfer is in irregular quantities and is not in a form or quantity capable of a fixed or definite price value. Therefore, body shops are generally deemed to be the consumers of materials and must pay tax on these items at the time of purchase. Nonexclusive examples of items most likely to be included in this category of “materials,” whether actually transferred to customers of body shops or not, are as follows:

- Abrasives
- Accessories
- Battery water
- Body filler or putty
- Body lead
- Bolts, nuts and washers
- Brake fluid
- Buffing pads
- Chamois
- Cleaning compounds
- Degreasing compounds
- Floor dry
- Hydraulic jack oil
- Lubricants
- Masking tape
- Paint
- Polishes
- Rags
- Rivets and cotter pins
- Sand paper
- Sanding discs

- Scuff pads
- Sealer and primer
- Sheet metal
- Solder
- Solvents
- Spark plug sand
- Striping tape
- Thinner
- Upholstery tacks
- Waxes
- White sidewall cleaner

The following are nonexclusive examples of parts which can be purchased for resale since they are generally transferred to the body shop's customer during the course of the repair in a form or quantity capable of a fixed or definite price value and are generally itemized separately as parts.

- Batteries
- Brackets
- Bulbs
- Bumpers
- Cab corners
- Chassis parts
- Doors
- Door guards
- Door handles
- Engine parts
- Fenders
- Floor mats
- Grills
- Headlamps
- Hoods
- Hub caps
- Radiators
- Rocker panels
- Shock absorbers
- Side molding
- Spark plugs
- Tires
- Trim
- Trunk lids
- Wheels
- Window glass
- Windshield ribbon
- Windshields

The following are nonexclusive examples of tools and supplies which are generally not transferred to the body shop's customer during the course of the repair and therefore could not be purchased for resale. The body shop is deemed the consumer of these items since they are not transferred to a customer and therefore the body shop must pay tax to the vendor at the time of purchase.

- Air compressors and parts
- Body frame straightening equipment
- Brooms and mops
- Buffers
- Chisels
- Drill bit

- Drop cords
- Equipment parts
- Fire extinguisher fluids
- Floor jacks
- Hand soap
- Hand tools
- Office supplies
- Paint brushes
- Paint sprayers
- Sanders
- Spreaders for putty
- Signs
- Washing equipment and parts
- Welding equipment and parts

Because of the nature of their business and the formulas devised by the insurance industry to reimburse body shops for cost of “materials,” it is possible for body shops, in their invoices to their customers, to separately set forth labor, resold parts, and materials. While the materials can be separately invoiced as one general item, there is no way to ascertain a definite and fixed price for each item of the materials listed in this rule and consumed by the body shops and some of such individual materials are not even transferred by body shops to their customers. Therefore, the body shops are generally the “consumers” of “materials” and do not purchase them for resale. *W.J. Sandberg Co. v. Iowa State Board of Assessments and Review*, 225 Iowa 103, 278 N.W. 643 (1938). Thus, body shops should pay tax to their suppliers on all materials purchased and consumed by them. If materials are purchased from non-Iowa suppliers who do not collect Iowa tax from body shops, such body shops should remit consumer use tax to the Department of Revenue on such materials.

Body shops must collect sales tax on the taxable service of repairing motor vehicles. See rule 701—26.5(422). However, due to the nature of the insurance formulas, it is possible for body shops to itemize that portion of their billing which would be for repair services and that portion relating to consumed “materials.” It is also possible for body shops to itemize that portion of their charges for parts which they purchase for resale to their customers. Body shops do not and cannot resell the tools and supplies previously listed in this rule and are taxable on their purchases of such items.

Therefore, as long as body shops separately itemize on their invoices to their customers the amounts for labor, parts, and for “materials,” body shops should collect sales tax on the labor and the parts, but not on the materials as enumerated in this rule.

EXAMPLE: A body shop repairs a motor vehicle by replacing a fender and painting the vehicle. In doing the repair work, the body shop uses rags, sealer and primer, paint, solder, thinner, bolts, nuts and washers, masking tape, sandpaper, waxes, buffing pads, chamois, solder and polishes. In its invoice to the customer, the labor is separately listed at \$300, the part (fender) is separately listed at \$300, and the category of “materials” is separately listed for a lump sum of \$100, for a total billing of \$700. The Iowa sales tax computed by the body shop should be on \$600 which is the amount attributable to the labor and the parts. The materials consumed by the body shop were separately listed and would not be included in the tax base for “gross taxable services” as defined in Iowa Code subsection 422.42(16), which is taxable in Iowa Code section 422.43.

In this example, if the “materials” were not separately listed on the invoice, but had been included in either or both of the labor or part charges by marking up such charges, the body shop would have to collect sales tax on the full charges for parts or labor even though tax was paid on materials by the body shop to its supplier at time of purchase.

This rule is intended to implement Iowa Code sections 422.42, 422.43 and 423.2.

701—18.32(422,423) Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations. Rescinded ARC 5201C, IAB 10/7/20, effective 11/11/20. See Delay note at end of chapter.

701—18.33(422,423) Printers' and publishers' supplies exemption with retroactive effective date.

18.33(1) For the purposes of this rule, a “printer” is any person, a portion of whose business involves the completion of a finished, printed product for sale at retail by that person or another person. A “printer” is also any person, a portion of whose business involves the completion of a finished printed packaging material used to package products for ultimate sale at retail. The term “printer” does not include any person printing or copyrighting printed material for its own use or consumption and not for resale. A “publisher” means and includes any person who owns the right to produce, market, and distribute printed literature and information for ultimate sale at retail.

18.33(2) Effective May 4, 1995, and retroactive to July 1, 1983, the gross receipts from the sale or rental of the following to a printer or publisher are exempt from tax: acetate; antihalation backing; antistatic spray; back lining; base material used as a carrier for light sensitive emulsions; blankets; blow-ups; bronze powder; carbon tissue; codas; color filters; color separations; contacts; continuous tone separations; creative art; custom dies and die cutting materials; dampener sleeves; dampening solution; design and styling; diazo coating; dot etching; dot etching solutions; drawings; drawsheets; driers; duplicate films or prints; electronically digitized images; electrotypes; end product of image modulation; engravings; etch solutions; film; finished art or final art; fix; fixative spray; flats; flying pasters; foils; goldenrod paper; gum; halftones; illustrations; ink; ink paste; keylines; lacquer; lasering images; layouts; lettering; line negatives and positives; linotypes; lithographic offset plates; magnesium and zinc etchings; masking paper; masks; masters; mats; mat service; metal toner; models; modeling; mylar; negatives; nonoffset spray; opaque film process paper; opaquing; padding compound; paper stock; photographic materials: acids, plastic film, desensitizer emulsion, exposure chemicals, fix, developers, paper; photography, day rate; photopolymer coating; photographs; photostats; photo-display tape; phototypesetter materials; pH-indicator sticks; positives; press pack; printing cylinders; printing plates, all types; process lettering; proof paper; proofs and proof processes, all types; pumice powder; purchased author alterations; purchased composition; purchased phototypesetting; purchased stripping and paste-ups; red litho tape; reducers; roller covering; screen tints; sketches; stepped plates; stereotypes; strip types; substrate; tints; tissue overlays; toners; transparencies; tympan; typesetting; typography; varnishes; Veloxes; wood mounts; and any other items used in a similar capacity to any of the above-enumerated items by the printer or publisher to complete a finished product for sale at retail. Expendable tools and supplies not enumerated in this subrule are subject to tax.

18.33(3) Claim for refunds of tax, interest, or penalty paid for the period of July 1, 1983, to June 30, 1995, must be limited to \$25,000 in the aggregate and will not be allowed unless filed prior to October 1, 1995. If the amount of claimed refunds for this period totals more than \$25,000, the department must prorate the \$25,000 among all claims.

701—18.34(422,423) Automatic data processing.**18.34(1) In general.**

a. Applicability of tax. For the purposes of this rule, the tax on automatic data processing is applicable to the gross receipts of:

- (1) Sales and rentals of data processing equipment (hardware).
- (2) Sales and rentals of tangible personal property produced or consumed by data processing equipment or prewritten (canned) computer software used in data processing operations.
- (3) Certain enumerated services performed on or connected with data processing such as rental of tangible personal property, machine repair, services of machine operators, office and business machines repair, electrical installation, and any other taxable service enumerated in Iowa Code section 422.43.

b. Definitions.

- (1) Rescinded by 2020 Iowa Acts, House File 2641, section 97, effective July 1, 2020.
- (2) “*Hardware*” means the physical computer assembly and peripherals including, but not limited to, such items as the central processing unit, keyboards, consoles, monitors, memory, disk and tape drives, terminals, printers, plotters, modems, tape readers, document sorters, optical readers and digitizers.

(3) “*Canned software*” is prewritten computer software which is offered for general or repeated sale or rental to customers with little or no modification at the time of the transaction beyond specifying the parameters needed to make the program run. Canned software is tangible personal property. The term also includes programs offered for general or repeated sale or rental which were initially developed as custom software. Evidence of canned software includes the selling or renting of the software more than once. Software may qualify as custom software for the original purchaser or lessor but is canned software with respect to all others. Canned software includes program modules which are prewritten and later used as needed for integral parts of a complete program.

(4) “*Custom software*” is specified, designed, and created by a vendor at the specific request of a customer to meet a particular need and is considered to be a sale of a service rather than a sale of tangible personal property. It includes those services represented by separately stated charges for the modification of existing prewritten software when the modifications are written or prepared exclusively for a customer. Modification to existing prewritten software to meet the customer’s needs is custom computer programming only to the extent of the modification and only to the extent that the actual amount charged for the modification is separately stated. Examples of services that do not result in custom software include loading parameters to initialize program settings and arranging preprogrammed modules to form a complete program.

When the charges for modification of a prewritten program are not separately stated, tax applies to the entire charge made to the customer for the modified program unless the modification is so significant that the new program qualifies as a custom program. If the prewritten program before modification was previously marketed, the new program will qualify as a custom program if the price of the prewritten program was 50 percent or less of the price of the new program. If the prewritten program was not previously marketed, the new program will qualify as a custom program if the charge made to the customer for custom programming services, as evidenced by the records of the seller, was more than 50 percent of the contract price to the customer.

The department will consider the following records in determining the extent of modification to prewritten software when there is not a separate charge for the modification: logbooks, timesheets, dated documents, source codes, specifications of work to be done, design of the system, performance requirements, diagrams of programs, flow diagrams, coding sheets, error printouts, translation printouts, correction notes, and invoices or billing notices to the client.

(5) “*Storage media*” includes hard disks, compact disks, floppy disks, diskettes, diskpacks, magnetic tape, cards, or other media used for nonvolatile storage of information readable by a computer.

(6) “*Rental*” includes any lease or license agreement between a vendor and a customer for the customer’s use of hardware or software.

(7) “*Program*” is interchangeable with the term “software” for purposes of this rule.

18.34(2) Taxable sales, rentals and services.

a. Sales of equipment. Tax applies to sales of automatic data processing equipment and related equipment.

b. Rental or leasing of equipment. Where a lease includes a contract by which a lessee secures for a consideration the use of equipment which may or may not be used on the lessee’s premises, the rental or lease payments are subject to tax. See rule 701—26.18 on tangible personal property rental.

c. Canned software. The sale or rental for a consideration of any computer software which is not custom software is a transfer of tangible personal property and is taxable. Canned software may be transferred to a customer in the form of diskettes, disks, magnetic tape, or other storage media or by listing the program instructions on coding sheets.

(1) Tax applies whether title to the storage media on which the software is recorded, coded, or punched passes to the customer or the software is recorded, coded, or punched on storage media furnished by the customer. A fee for the temporary transfer of possession of canned software for the purpose of direct use to be recorded, coded, or punched by the customer or by the lessor on the customer’s premises, is a sale or rental of canned software and is taxable.

(2) Tax applies to the entire amount charged to the customer for canned software. Where the consideration consists of license fees, royalty fees, right to use fees or program design fees, whether

for a period of minimum use or for extended periods, all fees includable in the purchase price are subject to tax.

d. Training materials. Persons who sell or lease data processing equipment may provide a number of training services with the sale or rental of their equipment. Training services, per se, are not subject to tax. Training materials, such as books, furnished to the trainees for a specific charge are taxable.

e. Services a part of the sale or lease of equipment. Where services, such as programming, training or maintenance services, are provided to those who purchase or lease automatic data processing and related equipment, on a mandatory basis as an inseparable part of the sale or taxable lease of the equipment, charges for the furnishing of the services are includable in the measure of tax from the sale or lease of the equipment whether or not the charges are separately stated. (Where the purchaser or lessee has the option to acquire the equipment either with the services or without the services, charges for the services may not be excluded from the measure of tax if they are taxable enumerated services.)

f. Materials and supplies. The transfer of title, for a consideration, of tangible personal property, including property on which or into which information has been recorded or incorporated is a sale subject to tax.

Generally service bureaus are consumers of all tangible personal property, including cards and forms, which they use in providing services unless a separate charge is made to customers for the materials, in which case, tax applies to the charge made for the materials.

g. Additional copies. When additional copies of records, reports, tabulation, etc., are sold, tax applies to the charges made for the additional copies. "Additional copies" are all copies in excess of those produced on multipart carbon paper simultaneously with the production of the original and on the same printer, whether the copies are prepared by rerunning the same program, by using multiple simultaneous printers, by looping a program such that the program is run continuously, by using different programs to produce the same output product, or by other means. Where additional copies are prepared, the tax will be measured by the charge made by the service bureau to the customer. If no separate charge is made for the additional copies, tax applies to that portion of the gross receipts which the cost of the additional computer time (if any) and the cost of materials and labor cost to produce the additional copies bear to the total job cost. Charges for copies produced by means of photocopying, multilithing, or by other means are subject to tax. Tax applies to a contract where data on magnetic tape are converted into combinations of alphanumeric printing, curve plotting or line drawings, and put on microfilm or photorecording paper.

h. Mailing lists. Addressing (including labels) for mailing. Where the service bureau addresses, through the use of its automatic data processing equipment or otherwise, material to be mailed, with names and addresses furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for addressing. Similarly, where the service bureau prepares, through the use of its automatic data processing equipment or otherwise, labels to be affixed to material to be mailed, with names and address furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for producing the labels, regardless of whether the service bureau itself affixes the labels to the material to be mailed. However, tax would be due on any tangible personal property, such as labels, consumed by the service bureau. (See "f" above.) Mailing lists in the form of Cheshire tapes, gummed labels, and heat transfers which are attached to envelopes and placed in the mail by a service bureau constitute tangible personal property and are subject to tax.

i. Services of a machine operator. The services of a machine operator, such as a key punch operator or the operator of any other data processing equipment, when hired to operate another person's machinery or equipment, are subject to tax when contracted for and performed by someone other than an employee of the owner of the machinery and equipment.

j. Maintenance contracts. Maintenance contracts sold in connection with the sale or lease of canned software generally provide that the purchaser will be entitled to receive storage media on which prewritten program improvements have been recorded. The maintenance contract may also provide that the purchaser will be entitled to receive certain services, including error corrections and telephone or on-site consultation services.

(1) Nonoptional maintenance contract. If the maintenance contract is required as a condition of the sale or rental of canned software, it will be considered as part of the sale or rental of the canned

software, and the gross sales price is subject to tax whether or not the charge for the maintenance contract is separately stated from the charge for software.

(2) Optional maintenance contracts prior to July 1, 1998. If the maintenance contract is optional to the purchaser of canned software, then only the portion of the contract fee representing improvements delivered on storage media is subject to sales tax if the fee for other services, including consultation services and error corrections, is separately stated. If the fee for other services, including consultation services and error corrections, is not separately stated from the fee for improvements delivered on storage media, the entire charge for the maintenance contract is subject to sales tax.

(3) Optional maintenance contracts on and after July 1, 1998. If an optional software maintenance or support contract provides for technical support services only, then no tax is imposed on the gross receipts from the performance of those services. If an optional software maintenance or support contract separately states the charges which represent improvements delivered on storage media from charges which represent other services, including consultation services and error correction, then only that portion of the contract fee representing improvements delivered on the storage media is subject to sales tax. If an optional software maintenance or support contract provides for the taxable transfer of tangible personal property and the provision of nontaxable services, and there is no separately stated charge for the taxable transfer of property or for the nontaxable service, then state sales tax of 5 percent shall be imposed on 50 percent of the gross receipts from the sale of such contracts. See 701—paragraph 18.25(3)“c” for more information.

18.34(3) Nontaxable items and activities.

a. Custom programs. These are programs prepared to the special order of a customer. Tax does not apply to the transfer of custom programs in the form of written procedures, such as program instructions listed on coding sheets. Tax applies to the sale of material transferred to the customer in the form of typed or printed sheets if separately invoiced.

b. Processing a client's data. Generally speaking, if a person enters into a contract to process a client's data by the use of a computer program, or through an electrical accounting machine programmed by a wired plugboard, the processing of a client's data is nontaxable. Such contracts usually provide that the person will receive the client's source documents, record data in machine readable form, such as in punch cards or on magnetic tape, make necessary corrections, rearrange or create new information as the result of the processing and then provide tabulated listings or record output on other media. This service will be considered nontaxable even if the total charge is broken down into specific charges for each step. The furnishing of computer programs and data by the client for processing under direction and control of the person providing the service is nontaxable even though charges may be based on computer time. The true object of these contracts is considered to be a service, even though some tangible personal property is incidentally transferred to the client. However, tax will apply to tangible personal property separately invoiced to the client.

c. Time sharing. Charges made for the use of automatic data processing equipment, on a time-sharing basis, where access to the equipment is by means of remote facilities, are not subject to tax. Time sharing which is, in fact, a rental of equipment and the lessee exercises the right of possession or control over the equipment is subject to tax. See 18.34(2)“b” and rule 701—26.18(422).

d. Designing of systems, converting of systems, consulting, training, and miscellaneous services. These services consist of the developing of ideas, concepts and designs. Common examples of these nontaxable services are:

(1) Designing and implementing computer systems (e.g., determining equipment and personnel required and how they will be utilized).

(2) Designing storage and data retrieval systems (e.g., determining what data communications and high speed input-output terminals are required).

(3) Converting manual systems to automatic data processing systems, converting present automatic data processing systems to new systems (e.g., changing a second generation system to a third generation system).

(4) Consulting services (e.g., studies of all or part of a data processing system).

(5) Feasibility studies (e.g., studies to determine what benefits would be derived if procedures were automated).

(6) Evaluation of bids (e.g., studies to determine which manufacturer's proposal for computer equipment would be most beneficial).

(7) Providing technical help such as analysts and programmers, usually on an hourly basis.

(8) Writing (coding) and testing of programs—contract programming. These services result in the production of customized programs. This type of service is not taxable because programming requires the development or ascertainment of information, and the evaluation of data, in addition to other development skills.

Persons engaged in providing nontaxable computer services are the consumers of all tangible personal property used in such activities, and the tax must be paid on their acquisition of such property.

This paragraph, 18.34(3) "d," shall become effective for periods beginning on or after April 1, 1992.

e. Installation charges. Where installation charges are separately contracted for or where no contract exists, are separately invoiced, or do not constitute enumerated taxable services, they are exempt from tax. See rule 701—15.14(422,423).

f. Pickup and delivery charges. The tax will not apply to pickup and delivery charges which are separately contracted for or where no contract exists, are separately invoiced.

g. Rental of computer programs. Prior to July 1, 1984, the rental of computer programs was not subject to tax since the program did not constitute equipment. *KTVO, Inc. vs. Bair*, 1977, Iowa 225 N.W.2d, 111. For the rule regarding prewritten (canned) programs subsequent to that date, see 18.3(2) "c."

This rule is intended to implement Iowa Code sections 422.42, 422.45 and 423.2 and Iowa Code Supplement section 422.43 as amended by 1998 Iowa Acts, Senate File 2288.

[see Rescission note at end of chapter]

701—18.35(422,423) Drainage tile. The sale or installation of drainage tile which is to be used in disease control, weed control, or the health promotion of plants or livestock produced as part of agricultural production for market is exempt from tax. Drainage tile, when purchased for these purposes, is therefore not subject to tax. In all other cases, drainage tile will be considered a building material and subject to tax under the provisions of Iowa Code subsection 422.42(9).

This rule is intended to implement Iowa Code sections 422.42(3), 422.42(9), and 423.2.

701—18.36(422,423) True leases and purchases of tangible personal property by lessors.

18.36(1) True leases and purchases by lessors prior to, on, and subsequent to July 1, 1978. The definition of a sale specified in Iowa Code subsection 422.42(2) does not include leases. Hence, the exemption from tax on sales for resale is inapplicable to the purchase of tangible personal property for the purpose of leasing such property to others, but not for the purpose of reselling such property. *Cedar Valley Leasing, Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979). However, even though the general rule is that the acquisition cost of tangible personal property purchased for the purpose of leasing it to others is subject to the Iowa sales or use tax, certain transactions are exempted from tax by statute. See subrule 18.36(4).

18.36(2) General. Prior to July 1, 1984, tax is due on the lease or rental payments derived from the service of equipment rental only and not from the lease or rental of other tangible personal property. See 701—subrule 26.18(1). Tax would also be due on the gross receipts received on the disposal of the tangible personal property provided no exemption exists. When property is purchased for the purpose of financing under a conditional sales contract, the property is purchased for resale, and the acquisition of the property is not subject to Iowa tax. See rule 701—16.47(422,423).

The gross receipts from the leasing of property for subletting purposes is exempt from tax as a resale of a service, but the lessee must collect tax on the gross receipts from subletting unless such subletting is otherwise exempt from tax.

a. Where a resident or nonresident lessor leases equipment to a resident or nonresident lessee and the lease contract is executed in Iowa and the equipment is delivered to the lessee in Iowa, the rental

payments are subject to Iowa sales tax, even if the equipment is taken by the lessee to another state. *Williams Rentals, Inc. v Tidwell*, 516 S.W.2d 614 (Tenn. 1974).

b. Where a nonresident lessor leases equipment to a resident or nonresident lessee and the lessee uses the equipment in Iowa, the nonresident lessor has the responsibility of collecting Iowa use tax on the lease payments, provided the lessor maintains a place of business in Iowa as provided in Iowa Code sections 423.1(6) and 423.9. Whether the lease agreement is executed in Iowa or not is irrelevant. *State Tax Commission v. General Trading Co.*, 322 U.S. 335, 64 S.Ct. 1028, 88 L.Ed 1309, (1944).

c. Where a lessee is the recipient of equipment rental services as defined in “*a*” and “*b*” above and no tax has been collected from such lessee by the lessor, the lessee should remit Iowa use tax to the department of revenue. In the event no tax is remitted, the department, in its discretion, may seek to collect the tax from the lessor or lessee. In the event that the lessee is the recipient of equipment rental services, and the lessor does not maintain a place of business in Iowa and does not collect use tax pursuant to Iowa Code section 423.10, such lessee shall remit tax on its rental payments to the department.

d. Where a resident lessor leases equipment to a nonresident lessee outside of Iowa, and the equipment is delivered to the lessee outside Iowa, the act of leasing is exempt from the Iowa sales tax on the rental payments. However, in the event the lessee brings the equipment into Iowa and uses it in Iowa, Iowa use tax applies to rental payments, but see “*g*” below.

e. Where a resident or nonresident lessor purchases tangible personal property in Iowa for subsequent lease in or out of Iowa and takes delivery of the equipment in Iowa, the lessor’s purchase is subject to Iowa sales tax. *Dodgen Industries, Inc. v. Iowa State Tax Commission*, 160 N.W.2d 289 (Iowa 1968).

f. When a resident or nonresident lessor purchases tangible personal property outside of Iowa for the purpose of leasing it in Iowa and the equipment is brought into Iowa and used by the resident or nonresident lessee in this state, the lessor is considered as having a “use” of the property in Iowa and Iowa use tax will apply to the lessor’s purchase price of the property, regardless whether or not the lessor makes any physical use of the property in Iowa. *Union Oil Company of California v. State Board of Equalization*, 1963, 34 Cal. Rpts. 872, 386 P.2d 496.

g. If a sales or use tax has already been paid to another state on the purchase price of equipment prior to the use of that equipment in Iowa, a tax credit against the Iowa use tax on the purchase price will be given. After the equipment is brought into Iowa, if a sales or use tax is properly payable and is paid to another state on the rental payments of equipment, for the same time the Iowa tax is imposed on such rentals, a tax credit against the Iowa use tax on such rental payments will be given. *Henneford v. Silas Mason Co.*, 1937, U.S.577, 57 S.Ct. 524, 51 L.Ed. 814.

18.36(3) Leases relating to vehicles subject to registration.

a. Vehicles as defined in Iowa Code subsections 321.1(4), (6), (8), (9), and (10) (motor trucks, truck tractors, road tractors, trailers, and semitrailers), except when designed primarily for carrying persons, can be purchased free of use tax when purchased for lease and actually leased for use outside Iowa if the subsequent sole use in Iowa is in interstate commerce or interstate transportation.

b. Tangible personal property which by means of fabrication, compounding, or manufacturing becomes an integral part of vehicles as defined in 18.36(3)“*a*” when manufactured for lease and actually leased to a lessee for use outside the state of Iowa, can be purchased free of use tax provided the sole subsequent use of the vehicle in Iowa is in interstate commerce or interstate transportation. (Iowa purchases which would be subject to Iowa sales tax do not qualify for this exemption.) See rule 701—33.7(423).

The provisions of “*a*” and “*b*” are effective for periods beginning on January 1, 1973. Also see 701—Chapter 34 of the rules relating to vehicles subject to registration.

18.36(4) Special rules for lessors on or after July 1, 1978. If tangible personal property is purchased for leasing, the purchase of the property is exempt from tax if the following conditions are met:

a. The person (lessor) purchasing the property is regularly engaged in the business of leasing,

b. The period of the lease is for more than one year for sales or property occurring from July 1, 1978, to May 18, 1997, inclusive; for sales of property occurring on and after May 19, 1997, the period of the lease must be for more than five months, and

c. The lease or rental receipts must be subject to tax under the service of equipment rental.

All three conditions must be met before the exemption applies.

If the exemption is properly claimed, it is lost when the property is made use of for any purpose other than leasing and the person claiming the exemption is liable for the tax based on the original purchase price. Tax paid on the leasing or rental payments would be allowed as a credit against the tax due on the purchase price.

In the following examples, assume, unless stated to the contrary, that the lease or rental receipts are subject to tax. The examples are written on the assumption that the period for an exempt lease is five months or longer. Thus, these examples are basically applicable to the period beginning May 19, 1997; however, the examples illustrate principles which are applicable to the purchase for lease exemption for periods longer than one year which was the requirements for exemption prior to May 19, 1997.

EXAMPLE: A restaurant makes a one-time purchase of office furniture which it leases to an insurance company for a period of four years. The purchase of office furniture by the restaurant would be subject to tax because the restaurant is not regularly engaged in the business of leasing. However, if the restaurant established a pattern of regularly purchasing office furniture or other tangible personal property for lease, the exemption would apply.

EXAMPLE: A company purchases a computer which will be leased for a period of three years, at which time the computer is returned to the company. The sole business of the company is to purchase this one computer for lease. The purchase of the computer is exempt from tax because the company is regularly engaged in the business of leasing.

EXAMPLE: A leasing company purchases three lawn mowers which will be leased to individuals for periods of time less than five months. The purchase of the lawn mowers by the leasing company would be subject to tax because the periods of the leases are for less than five months.

EXAMPLE: A leasing company purchases a computer which will be leased for a period of three years. The purchase of the computer is exempt from tax because the period of the lease is for more than five months.

EXAMPLE: A leasing company buys a computer. The company claims the exemption from tax, but the company uses the computer in its own operations. Tax is due on the original purchase price and the leasing company is liable for the tax due.

EXAMPLE: A leasing company purchases a copying machine which will be leased for a period of two years. After four months, the machine is returned to the leasing company and then the machine is immediately re-leased without being used by the leasing company for any other purpose. The exemption would apply because it was properly claimed and nothing occurred to cause loss of the exemption.

EXAMPLE: A leasing company purchases a copying machine which will be leased for a period of two years. After four months, the machine is returned and the leasing company then uses the machine in its own business. The exemption would no longer apply and the leasing company would be liable for the tax based on the original purchase price. Credit would be allowed against the tax due on the purchase price for any tax paid on the lease or rental payments. Assume the leasing company paid \$2,000 for the copying machine and charged \$200 per month plus \$10 in tax per month. Since the machine is returned and the exemption is not applicable, the leasing company would owe \$100 on the \$2,000 acquisition cost. However, the leasing company collected \$40 (four months x \$10) tax on the monthly rental charges. Allowing the credit for tax collected of \$40 against the total tax liability of \$100 leaves a net tax liability of \$60 owed by the leasing company.

EXAMPLE: A manufacturer and seller of office furniture also leases office furniture. The leases always run for a period longer than five months and the company usually has only two leases per year. The leasing operation only accounts for 1 percent of the company's total business. The company still qualifies for the exemption because it is regularly engaged in the business of leasing and the period of the lease is for more than five months.

EXAMPLE: A leasing company purchases an airplane from an aircraft dealer and leases it for a period of three years. The lease or rental payments are not taxed because of the exemption for transportation services. The leasing company would owe tax based on the acquisition cost because the lease or rental payments are not subject to tax under the service of equipment rental.

EXAMPLE: A leasing company purchases equipment and leases it to a lessee for a period of 18 months. For the first 3 months, the equipment is used by the lessee in making repairs to existing structures and the lease receipts are taxable. For the remainder of the lease period, the equipment is used in new construction of buildings and structures and the lease receipts are exempt from tax. The acquisition cost of the equipment is exempt because the exemption was properly claimed and was not subsequently lost by a use other than leasing.

EXAMPLE: A leasing company purchases from an Iowa retailer equipment on May 18, 1997, for the purpose of leasing it for a period of six months. The lease receipts will be taxable. The sales tax exemption on the acquisition cost to the lessor cannot be claimed because the sale occurred before May 19, 1997, and, at the time of the sale, no sales tax exemption applied to such acquisition cost. The exemption for acquisition cost should not be given a retroactive effect. *Jones v. Gordy*, 1935, 169 Md. 173, 180 Atl. 272.

EXAMPLE: A leasing company purchases equipment outside of Iowa on May 1, 1997. The lessee brings the equipment into Iowa on June 1, 1997, and uses it in Iowa. The lease period is nine months, and the lessee's use in Iowa is subject to Iowa use tax on the lease payments. Under these circumstances, the Iowa use tax exemption on the lessor's acquisition cost applies because it is the law in effect at the time of use in Iowa, not at the time of sale, which determines whether a use tax exemption applies. *City of Ames v. Iowa State Tax Commission*, 1955, 246 Iowa 1016, 71 N.W.2d 15; *Allis-Chalmers Mfg. Co. v. Iowa State Tax Commission*, 1958, 250 Iowa 193, 92 N.W.2d 129.

EXAMPLE: A leasing company purchases equipment not for resale and leases it to the lessee for a period of more than five months. After three months, the equipment is returned to the leasing company which then sells the equipment. Such sale is not part of the regular course of the leasing company's business. The exemption, though properly claimed, is lost because, by reason of such sale, the leasing company made use of the property for a purpose other than leasing or renting. Had the equipment been returned to the leasing company on or after five months and one day from the commencement of the lease period, and the leasing company then sold the equipment outside the regular course of its business or used the equipment in its business, the exemption for acquisition cost would not be lost. Had the equipment been purchased for resale and leased prior to such resale, the acquisition cost to the leasing company would be exempt from tax. *Herman M. Brown Co. v. Johnson*, 1957, 248 Iowa 1143, 82 N.W.2d 134. If the equipment is traded in toward the purchase price of other equipment by the leasing company, or if the leasing company disposes of the equipment after it is fully depreciated, the exemption for acquisition cost is not lost. Where sale of equipment outside the regular course of business is made by the leasing company, see also rule 18.28(422) to determine whether the casual sale exemption applies to the receipts from such sale.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee. Assume that the exemption for acquisition cost of the equipment was properly claimed. Thereafter, the lessee makes an assignment of the lease. The exemption is not lost since the assignee stands in the same position as the original lessee and such an assignment does not change the nature of the original lease period. *Berg v. Ridgway*, 1966, 258 Iowa 640, 140 N.W.2d 95.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. The leasing company sells the lease contracts, as commercial paper, to others. The exemption for acquisition cost can still be claimed and such sales of lease contracts do not cause loss of the exemption.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. Thereafter, the lease can no longer be performed because the property is destroyed by an act of God. The acquisition cost exemption is not lost.

EXAMPLE: A leasing company purchases equipment which is leased to the lessee in accordance with the criteria creating the acquisition cost exemption. Thereafter, the lessee is adjudged bankrupt and the equipment is returned to the leasing company and is re-leased without being used by the leasing company for any other purpose. The acquisition cost exemption is not lost since the leasing company makes no use for any purpose other than leasing or renting.

EXAMPLE: A leasing company purchases equipment which is leased to a lessee. The criteria for the acquisition cost exemption are present. The lessee then sublets the equipment to another for a period less than five months. The acquisition cost exemption is not lost.

18.36(5) *Lease or rental of all tangible personal property now subject to tax.* On and after July 1, 1984, the lease or rental of all tangible personal property is subject to tax. See rule 701—26.18(422) for information concerning additional transactions subject to tax after that effective date.

This rule is intended to implement Iowa Code sections 422.42(2), 422.43, 422.45, 423.1, and 423.4.

701—18.37(422,423) Motor fuel, special fuel, aviation fuels and gasoline.

18.37(1) *In general.* The gross receipts from the sale of motor fuel and special fuel are exempt from sales tax under Iowa Code section 422.45(11) if (1) the fuel is consumed for highway use, in watercraft, or in aircraft, (2) the Iowa fuel tax has been imposed and paid, and (3) no refund or credit of fuel tax has been made or will be allowed. However, beginning July 1, 1985, the gross receipts from the sale of special fuel for diesel engines used in commercial watercraft on rivers bordering Iowa are exempt from sales tax, even though no fuel tax has been imposed and paid, providing the seller delivers the fuel to the owner's watercraft while it is afloat. Prior to July 1, 1988, retail sales of aviation gasoline were not exempt from sales tax under Iowa Code subsection 422.45(11). See subrule 18.37(4).

18.37(2) *Refunds or credits of motor fuel and special fuel.* Claims for refund or credit of fuel taxes under the provisions of Iowa Code chapter 452A must be reduced by any sales or use tax owing the state unless a sales tax exemption is applicable. Generally, refund claims or credits are allowed where fuel is purchased tax paid and used for purposes other than to propel a motor vehicle or used in watercraft.

18.37(3) *Refunds of tax on fuel purchased in Iowa and consumed out of Iowa.* Even though fuel is purchased in Iowa, fuel tax paid in Iowa, and the fuel tax is subject to refund under the provisions of division III of Iowa Code chapter 452A relating to interstate motor vehicle operations, the refund of the fuel tax does not subject the purchase of the fuel to sales tax. Subjecting the purchase to sales tax has the effect of imposing sales tax when fuel is consumed in interstate commerce while fuel consumed on Iowa highways in intrastate commerce is exempt from sales tax pursuant to Iowa Code subsection 422.45(11). The effect for sales tax purposes is to impose a greater tax burden on non-Iowa highway fuel consumption than Iowa highway fuel consumption thereby discriminating against interstate commerce. In addition, the effect of imposing sales tax on interstate excess purchases where intrastate highway use is not subject to the tax constitutes an export duty for purchasing fuel in Iowa and exporting it for use in another state. Such effects are in violation of the commerce clause of the United States Constitution. *Boston Stock Exchange v. State Tax Commission*, 1977, 429 U.S. 319, 97 S.Ct. 599, 50 L.Ed.2d 514 and *Coe v. Errol*, 1886, 116 U.S. 517, 6 S.Ct. 475, 29 L.Ed. 715.

18.37(4) *Aviation gasoline.* Tax treatment prior to July 1, 1988. Prior to July 1, 1988, all Iowa fuel tax paid on aviation gasoline used in aircraft was refundable under Iowa Code section 452A.17. Generally, aviation gasoline is not purchased for highway use or for use in watercraft, therefore, the exemption from sales and use tax found in Iowa Code subsection 422.45(11) was generally not applicable to purchases of aviation gasoline. However, Iowa Code subsection 422.52(4) provides for the collection of sales tax by way of deduction from motor fuel tax refunds allowable under Iowa Code chapter 452A. Therefore, sales tax is not assessed at the retail level but only in instances where the fuel tax paid on aviation gasoline has been refunded. If no application for a fuel tax refund relating to aviation fuel has been made, no sales tax is assessed on the aviation gasoline purchase.

18.37(5) *Ethanol.* For tax periods after April 30, 1981. Retail sales of ethanol are exempt from Iowa sales or use tax.

18.37(6) *Tax base.* The basis for computing the Iowa sales tax will be the retail selling price of the fuel less any Iowa fuel tax included in such price. Federal excise tax should not be removed from the selling price in determining the proper sales tax due. *W.M. Gurley v. Army Rhoden* supra. Also see rule 701—15.12(422,423).

This rule is intended to implement Iowa Code sections 422.31, 422.43, 422.45(11), 422.45(22), 422.52(4), 423.1, 452A.3, and 452A.17.

701—18.38(422,423) Urban transit systems. A privately owned urban transit system which is not an instrumentality of federal, state or county government is subject to sales tax on fuel purchases which are within the urban transit systems charter.

Tax shall not apply to fuel purchases, made by a privately owned urban transit company, for use outside the urban transit system charter in which a fuel tax has been imposed and paid and no refund has been or will be allowed.

Whether an urban transit company will be considered an instrumentality of federal, state or county government for the purpose of receiving sales tax exemption on its fuel purchases, which are also exempted from fuel tax and used for public purposes, depends upon consideration of the following:

1. Whether it is created by government.
2. Whether it is wholly owned by government.
3. Whether it is operated for profit.
4. Whether it is primarily engaged in the performance of some essential governmental function.
5. Whether the payment of tax will impose an economic burden upon the corporation, or that payment of tax serves to materially impair the usefulness or efficiency of the corporation or the payment of tax materially restricts the corporation in the performance of its duties.

These above enumerated considerations are not all inclusive and the presence of some and absence of others does not necessarily establish the exemption. *Unemployment compensation of North Carolina v. Wachovia Bank and Trust Company*, 2 S.E.2d 592, 595, 215 No. Car. 491 (1939); 1976 O.A.G. 823, 827, 828.

This rule is intended to implement Iowa Code subsection 422.45(1).

701—18.39(422,423) Sales or services rendered, furnished, or performed by a county or city. The gross receipts from the sales, furnishing, or service of gas, electricity, water, heat, and communication service rendered, furnished, or performed by a county or city are subject to the tax. On and after July 1, 1985, the gross receipts from fees paid to cities and counties for the privilege of participating in any athletic sports are also subject to tax. On or after July 1, 1991, the gross receipts from any municipally owned pay television service are taxable as well. On and after April 1, 1992, the gross receipts from a county or municipality furnishing sewage service or solid waste collection and disposal service to nonresidential commercial operations are taxable (see rules 701—26.71(422,423) and 26.72(422,423) for more information).

Any other sales or services rendered, furnished, or performed by a county or city are not subject to the tax.

A “sport” is any activity or experience which involves some movement of the human body and gives enjoyment or recreation. An “athletic” sport is any sport which requires physical strength, skill, speed, or training in its performance. The following activities are nonexclusive examples of athletic sports: baseball, football, basketball, softball, volleyball, golf, tennis, racquetball, swimming, wrestling, and foot racing.

The following is a list of various fees which would be considered fees paid to a city or county for the privilege of participating in any athletic sport, and thus subject to tax under this rule. The list is not exhaustive.

1. Fees paid for the privilege of using any facility specifically designed for use by those playing an athletic sport: fees for use of a golf course, ball diamond, tennis court, swimming pool, or ice skating rink are subject to tax. These fees are subject to tax whether they allow use of the facility for a brief or extended period of time, e.g., a daily fee or season ticket for use of a swimming pool or golf course would be subject to tax. Group rental of facilities designed for playing an athletic sport would also be subject to tax.

2. Fees paid to enter any tournament or league which involves playing an athletic sport would be subject to tax. Both team and individual entry fees are taxable. Fees paid to enter any marathon or foot race of shorter duration would be subject to tax under this rule.

Not subject to tax as fees paid to a city or county for the privilege of participating in any athletic sport under this rule are the following charges. The list is not intended to be exhaustive.

1. Fees paid for lesson or instruction in how to play or to improve one's ability to play an athletic sport are not subject to tax. Golf and swimming lesson fees are specific examples of such nontaxable charges. The fees are excluded from tax regardless of whether the person receiving the instruction is a child or an adult. Fees charged for equipment rental, regardless of whether this equipment is helpful or necessary to participation in an athletic sport, are not subject to tax. The rental of a golf cart or moveable duck blind would not be subject to tax. The rental of a recreational boat is a transportation service, the gross receipts of which are not subject to tax if provided by a city or county.

2. Sales of merchandise, e.g., food or drink, to persons watching or participating in any athletic sport are not subject to tax.

3. Fees charged to improve any facility where any athletic sport is played are not subject to tax, unless such a fee must be paid to participate in an athletic sport which can be played within the facility.

4. Fees paid by any person or organization to rent any county or city facility or any portion of any county or city park shall not be subject to tax unless the portion of the park or facility is specifically designed for the playing of an athletic sport.

EXAMPLE: A local bridge club pays a fee to use a shelter house and the surrounding grounds at a county park for a picnic. During the course of the picnic, the club members set up a net and use the surrounding grounds to play volleyball. They also improvise a softball field and play a softball game there. The fee which the bridge club has paid to rent the shelter house and surrounding grounds would not be subject to tax.

5. Fees paid for the use of a campground or hiking trail are not subject to tax.

This rule is intended to implement Iowa Code sections 422.43 and 422.45.

701—18.40(422,423) Renting of rooms. The gross receipts from the renting of any and all rooms, including but not limited to sleeping rooms, banquet rooms or conference rooms in any hotel, motel, inn, public lodging house, rooming or tourist court, or in any place where sleeping accommodations are furnished to transient guests, whether with or without meals, are subject to the tax. The rental of a mobile home or of manufactured housing which is tangible personal property is treated as room rental rather than tangible personal property rental. The renting of all rooms would be exempt from the tax if rented by the same person for a period of more than 31 consecutive days. The renter must contract to rent for a single period of 31 days or more. The renter may not accumulate these 31 days by contracting for two or more rental transactions. The incremental manner in which the hotel, motel, inn, public lodging house, rooming or tourist court, or any place where sleeping accommodations are furnished to transient guests bills its customers does not influence the accumulation of days that is required to claim the exemption.

This rule is intended to implement Iowa Code section 422.43.

701—18.41(422,423) Envelopes for advertising.

18.41(1) Some envelopes which contain advertising are exempt from tax. Envelopes which are not primarily used for advertising are taxable. The primary use of the envelopes should control whether they will be taxable or exempt. *Iowa Movers and Warehouseman's Assn. v. Briggs*, 237 N.W.2d 759 (Iowa 1976).

EXAMPLE 1: XYZ mails coupons and advertisements to persons giving discounts on a certain item which is sold at retail. The envelope used to package these materials is exempt from tax since it is primarily used to contain advertising materials.

EXAMPLE 2: XYZ mails a monthly billing statement to its charge account customers. In addition to the billing statement, XYZ Company encloses an advertisement in the envelope. The envelope has a dual purpose: (1) the collection of accounts receivable and (2) the distribution of advertising. However, the envelope is not primarily used for advertising but for billing the customer, therefore, the exemption does not apply.

18.41(2) Because of the difficulty of administering this exemption, purchasers of envelopes may petition to the department for permission to use a formula to represent to the seller the portion of taxable and exempt gross receipts from envelope purchases.

This rule is intended to implement Iowa Code subsection 422.45(9).

701—18.42(422,423) Newspapers, free newspapers and shoppers' guides.

18.42(1) General observations. The gross receipts from the sales of newspapers, free newspapers, and shoppers' guides are exempt from tax. The gross receipts from the sales of magazines, newsletters, and other periodicals which are not newspapers are taxable. Recent cases decided by the United States Supreme Court and the Supreme Court of Iowa prohibit exempting from taxation the sale of any periodical if that exemption from taxation is based solely upon the contents of that periodical. See *Arkansas Writers' Project, Inc. v. Ragland*, 481 U.S. 221, 107 S.Ct. 1722, 95 L.Ed.2d 209 (1987) and *Hearst v. Iowa Department of Revenue & Finance*, 461 N.W.2d 295 (Iowa 1990).

18.42(2) General characteristics of a newspaper. "Newspaper" is a term with a common definition. A "newspaper" is a periodical, published at short, stated, and regular intervals, usually daily or weekly. It is printed on newsprint with news ink. The format of a newspaper is that of sheets folded loosely together without stapling. A newspaper is admitted to the U.S. mails as second-class material. Other frequent characteristics of newspapers are the following:

a. Newspapers usually contain photographs. The photographs are more often in black and white rather than color.

b. Information printed on newspapers is usually contained in columns on the newspaper pages.

c. The larger the cross section of the population which reads a periodical in the area where the periodical circulates, the more likely it is that the department will consider that periodical to be a "newspaper."

18.42(3) Characteristics of newspaper publishing companies. Companies in the business of publishing newspapers are differently structured from other companies. Often, companies publishing larger newspapers will subscribe to various syndicates or "wire services." A larger newspaper will employ a general editor and a number of subordinate editors as well, for example, sports and lifestyle editors; business, local, agricultural, national, and world news editors; and editorial page editors. A larger newspaper will also employ a variety of reporters and staff writers. Smaller newspapers may or may not have these characteristics or may consolidate these functions.

18.42(4) Characteristics which distinguish a newsletter from a newspaper. A "newsletter" is generally distributed to members or employees of a single organization and not usually to a large cross section of the general public. It is often published at irregular intervals by a volunteer, rather than the paid individual who usually publishes a newspaper. A newsletter is often printed on sheets which are held together at one point only by a staple, rather than folded together.

This rule is intended to implement Iowa Code section 422.45(9).

701—18.43(422,423) Written contract. On and after July 1, 1985, the gross receipts from certain additional services are subject to tax. However, these newly taxable services are exempt from tax if performed pursuant to a written services contract in effect on April 1, 1985. The exemption from taxation for these services expires June 30, 1986. The services to which this "written contract" exemption is applicable are the following: cable television; campgrounds; gun repair; janitorial and building maintenance or cleaning; lawn care, landscaping and tree trimming and removal; lobbying service; pet grooming; reflexology; security and detective services; tanning beds or salons; water conditioning and softening; the rental of recreational vehicles, recreational boats or motor vehicles subject to registration which are registered for a gross weight of 13 tons or less; and fees paid to cities and counties for the privilege of participating in any athletic sports.

A "written contract" is one which is entirely in writing, so that all of its essential terms and provisions exist in writing, and oral statements are not necessary to set out any essential term or provision, such as who the parties to the contract are or what their rights and duties are under the contract. However, if it is necessary to resort to oral statements to explain the meaning of a written provision in a contract, a "written contract" can still exist. A written contract need not consist of one document or instrument only. It can consist of two or more writings, if all the necessary provisions of the contract are contained in those writings. For the purposes of this rule, the following must be stated in writing if a written contract is to exist: The nature and specification of the service to be provided, the name of the party providing the service, the name of the party receiving the service, the "consideration" (amount and method of

payment) for providing the service, the signature of one or both of the parties to the contract, depending upon circumstances, and the date upon which the contract became effective.

The written contract must be in effect on April 1, 1985, if the service to which the contract pertains is to be exempt from tax. If a contract is signed by only one of the parties to it, that contract is still a “written contract” if the party which has not signed the contract acquiesces in the promises which the party who has signed the document makes within it. *McDermott v. Mahoney*, 139 Iowa 292, 115 N.W. 32, (Iowa 1908).

EXAMPLE: A security agency sends a proposed agreement to a potential customer promising to provide the services of a uniformed security guard for the customer’s business premises beginning March 15, 1985, and continuing until March 15, 1987. The agreement is signed by the security agency’s president and dated February 15, 1985. The agreement is received by the potential customer’s president, who does not sign it, but, on March 15, 1985, allows the security agency’s uniformed guard on the premises, and makes payment for those services as stipulated in the agreement. This agreement is a “written contract”; the services of the uniformed guard are not subject to tax for the period beginning July 1, 1985, and ending June 30, 1986. The services performed between July 1, 1986, and March 15, 1987, would be subject to tax.

This rule is intended to implement Iowa Code subsection 422.43(11).

701—18.44(422,423) Sale or rental of farm machinery and equipment. On and after July 1, 1987, the gross receipts from the sale or rental of farm machinery and equipment will be exempt from tax. Effective July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case or other similar article or receptacle sold for use in agricultural, livestock or dairy production are not subject to sales tax.

18.44(1) Characteristics of and limitations upon farm machinery and equipment. To be eligible for exemption from or refund of tax under this rule the machinery or equipment must:

- a. Be directly and primarily used in production of agricultural products; and
- b. Be one of the following:
 - (1) A self-propelled implement; or
 - (2) An implement customarily drawn or attached to a self-propelled implement; or
 - (3) A grain dryer; or
 - (4) An auxiliary attachment which improves the performance, safety, operation, or efficiency of a qualifying implement or grain dryer if sale or first use in Iowa is on or after July 1, 1995; or
 - (5) A replacement part for any item described in subparagraph (1), (2), (3), or (4).
 - (6) Effective July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock or dairy production.
- c. No vehicle subject to registration, as defined in Iowa Code subsection 423.1(7), implement customarily drawn or attached to a vehicle, auxiliary attachment, or any replacement part for a vehicle, implement, or auxiliary attachment is eligible for the exemption or refund allowed under this rule.

18.44(2) Definitions and characterizations. For the purposes of this rule, the following definitions apply.

a. Production of agricultural products means the same as the term “agricultural production” which is defined in 701—subrule 17.9(3), paragraph “a,” to mean a farming operation undertaken for profit by raising crops or livestock. Production of agricultural products begins with the cultivation of land previously cleared for planting of crops or with the purchase or breeding of livestock or domesticated fowl. Not included within the meaning of the phrase are the clearing or preparation of previously uncultivated land, the creation of farm ponds or the erection of machine sheds, confinement facilities, storage bins or other farm buildings. See *Trullinger v. Fremont County*, 223 Iowa 677, 273 N.W. 124 (1937). Machinery and equipment used for these purposes would be used for activities which are preparatory to but not a part of the production of agricultural products. The production of agricultural products ceases when an agricultural product has been transported to the point where it will be sold by the farmer or processed.

EXAMPLE. Farmer Brown uses a tractor and wagon to haul harvested corn from a field to a grain dryer located on the farm. After the corn is dried, the same tractor and wagon are used to move the grain to a storage bin, also located on the farm. Later the same tractor and wagon are used to deliver the corn from the farm to the local elevator where it is sold. After Farmer Brown deposits the corn there, the local elevator uses its own tractor and wagon to move the corn to a place of relatively permanent storage. Farmer Brown has used the tractor and wagon in the production of agricultural products and the refund or exemption would apply. The elevator has not used its tractor and wagon in such production; refund or exemption would not be lawful.

b. Farm machinery and equipment means machinery and equipment specifically designed for use in the production of agricultural products or equipment and machinery not specifically designed for this use but which are directly and primarily used in the production of agricultural products.

EXAMPLE. Farmer Jones raises livestock and the farming operation requires that fences be built to confine the livestock. Farmer Jones purchases a posthole digger that is customarily attached to a tractor and uses the digger to construct the fences used to confine the livestock. The posthole digger is not specifically designed for use in the production of agricultural products but would be directly and primarily used in the production of agricultural products. Therefore, the exemption or refund applies.

c. Self-propelled implement has the same meaning as in 701—subrule 17.9(5), paragraph “c,” where the term is defined to mean an implement which is capable of movement from one place to another under its own power. The term self-propelled implement includes but is not limited to the following items: skidloaders and tractors; and the following machinery if capable of movement under its own power: combines, corn pickers, fertilizer spreaders, hay conditioners/windrowers, sprayers, and bean buggies.

d. Implements customarily drawn or attached to self-propelled implements. The following is a nonexclusive, representative list of implements which are customarily drawn or attached to self-propelled implements: Augers, balers, blowers, combines, conveyers, cultivators, disks, drags, dryers (portable), farm wagons, feeder wagons, fertilizer spreaders, front- and rear-end loaders, harrows, hay loaders, mowers and rakes, husking machines, manure spreaders, planters, plows, rotary blade mowers, rotary hoes, sprayers and tanks, and tillage equipment.

e. Direct use in agricultural production. In determining whether farm machinery, equipment or any grain dryer is directly used in agricultural production, the fact that particular machinery or equipment is essential to the production of agricultural products because its use is required either by law or practical necessity does not, of itself, mean that the machinery or equipment is directly used in the production of agricultural products. Machinery or equipment coming into actual physical contact with the soil or crops during the operations of planting, cultivating, harvesting, and soil preparation will be presumed to be machinery or equipment used in agricultural production.

f. Grain dryer. The term grain dryer includes the heater and the blower necessary to force the warmed air into a grain storage bin. It does not include equipment used in grain storage or movement such as augers and spreaders or any other equipment that is not a grain dryer. Equipment other than a grain dryer which is used in grain drying may be exempt or subject to refund if the equipment is a self-propelled implement or customarily drawn or attached to a self-propelled implement.

g. Replacement parts, differing meanings of the term for the period ending June 30, 1988, and for the period beginning July 1, 1988.

(1) For the period beginning July 1, 1985, and ending June 30, 1988, a replacement part is refundable or exempt only if its cost is depreciable for state and federal income tax purposes. Replacement parts which are depreciable for state and federal income tax purposes include only those replacement parts which either materially add to the value of machinery or equipment or appreciably prolong its life. Replacement parts which only keep the machinery or equipment in its ordinarily efficient operating condition are not eligible for exemption or refund. Included within the meaning of replacement parts is any part the cost of which is depreciable for state and federal income tax purposes but which may also be deducted as a current expense. So long as the cost is depreciable the sale or lease of the replacement part is eligible for refund or exemption from tax. However, the person claiming the

refund or exemption must show that the replacement part which was deducted as an expense could have been depreciated under state and federal income tax law.

(2) On and after July 1, 1988, the sale or lease of a replacement part is exempt from tax if the replacement part is essential to any repair or reconstruction necessary to farm machinery or equipment's exempt use in the production of agricultural products. The term "replacement part" does not include attachments and accessories which are not essential to the operation of the farm machinery or equipment. Nonexclusive examples of attachments or accessories are: cigarette lighters, radios, and add-on air-conditioning units.

18.44(3) *Taxable and nontaxable transactions.* The following are nonexclusive examples of sales and leases of farm machinery and equipment which are or are not subject to exemption and refund.

a. A lessor's purchase of farm machinery and equipment is not subject to tax, or is taxable subject to refund, if the machinery or equipment is leased to a lessee who uses it directly and primarily in the production of agricultural products and if the lessee's use of the machinery or equipment is otherwise exempt or subject to refund. To claim exemption from tax or a refund of tax paid, the lessor need not make exempt use of the machinery or equipment so long as the lessee does.

b. To claim refund or exemption, the owner or lessee of farm machinery or equipment need not be a farmer so long as the machinery and equipment is directly and primarily used in the production of agricultural products, and the owner or lessee and the equipment or machinery meet the other requirements of this rule. For example, a person who purchases an airplane designed for use in agricultural aerial spraying and so used after purchase is entitled to the benefits of this rule even though that person is not the owner or occupant of the land where the airplane is used.

c. The sale or lease, within Iowa, of any farm machinery, equipment, or replacement part for direct and primary use in agricultural production outside of Iowa is a transaction eligible for refund or exemption if those transactions are otherwise qualified under this rule.

18.44(4) *Auxiliary attachments.* The following is a list (not inclusive) of auxiliary attachments described in 18.44(1) "b"(4), the sale or first use in Iowa which is exempt from tax on and after July 1, 1995: auxiliary hydraulic valves, cabs, coil tine harrows, corn head pickup reels, dry till shanks, dual tires, extension shanks, fenders, fertilizer attachments and openers, fold kits, grain bin extensions, herbicide and insecticide attachments, kit wraps, no-till coulters, quick couplers, rear wheel assists, rock boxes, rollover protection systems, rotary shields, stalk choppers, step extensions, trash whips, upperbeaters, silage bags, and weights.

18.44(5) and 18.44(6) Rescinded IAB 9/7/88, effective 10/12/88.

This rule is intended to implement Iowa Code subsections 422.43(3) and 422.45(26), Iowa Code chapter 422, Division IV, and Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.

701—18.45(422,423) Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997. Rescinded ARC 5798C, IAB 7/28/21, effective 9/1/21.

701—18.46(422,423) Automotive fluids. The gross receipts from the sales of certain automotive fluids are exempt from tax. To be considered exempt, the sale must possess the following characteristics: (1) the sale must be to a retailer who will install the automotive fluid in or apply the automotive fluid to a motor vehicle; and (2) the installation or application must be done while the retailer is providing a taxable enumerated service (e.g., automobile lubrication); or (3) the automotive fluid must be installed in or applied to a motor vehicle which the retailer intends to sell and the sale of which will be subject to Iowa use tax.

Specific but nonexclusive examples of "automotive fluids" are motor oil and other automobile lubricants, hydraulic, brake, and transmission fluids, sealants, undercoatings, antifreeze, and gasoline additives.

This rule is intended to implement Iowa Code section 422.45(33).

701—18.47(422,423) Maintenance or repair of fabric or clothing.

18.47(1) As of July 1, 1987, sales of chemicals, solvents, sorbents, or reagents consumed in the maintenance or repair of fabric or clothing are exempt from tax. See 701—subrule 17.14(1) for definitions of the terms “chemical, solvent, sorbent or reagent.” This subrule’s exemption is mainly applicable to dry-cleaning and laundry establishments; however, it is also applicable to soap or any chemical or solvent used to clean carpeting. The department presumes that a substance is “directly used” in the maintenance or repair of fabric or clothing if the substance comes in contact with the fabric or clothing during the maintenance or repair process. Substances which do not come into direct contact with fabric or clothing may, under appropriate circumstances, be directly used in the maintenance or repair of the fabric or clothing but direct use will not be presumed.

The following are examples of substances directly used and consumed in the maintenance or repair of fabric or clothing: perchloroethylene “perch” or petroleum solvents used in dry-cleaning machines and coming in direct contact with the clothing being dry-cleaned. Substances used to clean or filter the “perch” or petroleum solvents would also be exempt from tax, even though these substances do not come in direct contact with the clothing being cleaned. The sale of soap or detergents especially made for mixing with “perch” or petroleum solvents is exempt. The sale of stain removers to dry cleaners is exempt from tax.

A commercial laundry’s purchase of detergents, bleaches, and fabric softeners is exempt from tax. A commercial laundry’s purchase of water, which is a solvent, is also exempt from tax if purchased for use in the cleaning of clothing.

The purchase of starch by laundries and “sizing” by dry cleaners is not exempt from tax.

18.47(2) Also, on and after July 1, 1987, the sale of property which is a container, label, or similar article or receptacle for transfer in association with the maintenance or repair of fabric or clothing is exempt from tax. In general, the sale of any article which protects dry-cleaned or laundered clothing from dirt or helps the dry-cleaned or laundered clothing to maintain its proper shape or form in the same fashion as a container does would be exempt from tax under this subrule. By way of nonexclusive example, the sale of plastic garment bags, which protect clothing from dirt, is exempt from tax. The sale of “shirt boards” and garment hangers, both of which help clothing to maintain its proper shape, would also be exempt.

A container, label, or similar article’s sale is exempt from tax only if the item is transferred to the customer of a commercial laundry, dry cleaner, or other retailer. Thus, “bundle bags” and “meese carts,” used to transfer or transport clothing within a dry-cleaning establishment, are not subject to the exemption because these bags and carts remain with the dry cleaner and are not transferred to a customer.

Concerning labels, the sale of which would be exempt from tax, these labels must be affixed to the dry-cleaned or laundered clothing and transferred to the customer of the dry-cleaning or laundering establishment. By way of nonexclusive example, the sale to dry cleaners, of “special attention,” “invoice” and “sorry” tags would be exempt from tax.

The sale of safety pins and other types of clips used to hang skirts and other garments from hangers would not be exempt from tax. These items do not sufficiently resemble containers or labels to the extent that their sale is exempt from tax.

This rule is intended to implement Division IV of Iowa Code chapter 422.

701—18.48(422,423) Sale or rental of farm machinery, equipment, replacement parts, and repairs used in livestock, dairy, or plant production. Sales or rental of farm machinery and equipment used in livestock or dairy production and replacement parts which occur on or after July 1, 1988, are exempt from sales and use tax. On and after July 1, 1995, machinery, equipment, and replacement parts used in the production of flowering, ornamental, or vegetable plants are exempt from tax. See rule 701—18.57(422,423).

18.48(1) Definitions and characterizations. For the purposes of this rule, the following definitions and characterizations of words apply.

a. “Machinery” means major mechanical machines or major components thereof which contribute directly and primarily to the livestock or dairy production process. Usually, a machine is a large object

with moving parts which performs work by the expenditure of energy, either mechanical (e.g., gasoline or kerosene) or electrical.

b. “Equipment” is tangible personal property (other than a machine) directly and primarily used in livestock or dairy production. It may be characterized as property which performs a specialized function which, of itself, has no moving parts or if it does possess moving parts, its source of power is external to it. The following examples attempt to differentiate between machinery and equipment:

EXAMPLE A. An electric pump is used to pump milk into a bulk milk tank. The electric pump is machinery; the bulk milk tank is equipment.

EXAMPLE B. An auger places feed into a cattle feeder. If not “real property” (see 18.48(1) “c”) the auger is a piece of machinery; the cattle feeder is a piece of equipment.

c. Property used in livestock or dairy production which is neither “equipment” nor “machinery.”

(1) Real property. The ground or the earth is not machinery or equipment. A building is not machinery or equipment, *Mid-American Growers, Inc. v. Dept. of Revenue*, 493 N.E.2d 1097 (Ill. App. Ct. 1986). Therefore, tangible personal property which is sold for incorporation into the ground or a building in such a manner that it will become a part of the ground or the building is taxable. Generally, property incorporated into the ground or a building has become a part of the ground or the building if removal of the property from the ground or building will substantially damage the property, ground, or building or substantially diminish the value of the property, ground, or building. Fence posts embedded in concrete and electrical wiring, light fixtures, fuse boxes, and switches are examples of property sold for incorporation into the ground or a building, respectively. The property referred to in 18.48(1) “c”(1) can be identified by applying the following test: Assume that the property is being sold to a contractor rather than a person engaged in livestock or dairy production. If sold to a contractor, would the retailer be required to consider the property “building material” and charge the contractor sales tax upon the purchase of this building material. If this is the case, sale of the property is not exempt from Iowa tax law. Iowa department of revenue rule 701—19.3(422,423) contains a characterization of “building material” and a list of specific examples of building material.

(2) “Supplies” are neither machinery nor equipment. Tangible personal property is part of farm supplies if it is used up or destroyed by virtue of its use in livestock or dairy production or, because of its nature, can only be used once in livestock or dairy production. A light bulb is an example of a farm supply which is not machinery or equipment. The sale of some farm supplies is exempt from tax. See 701—subrule 17.9(3). See List B in subrule 18.48(7) for examples of farm supplies which could be mistaken for equipment and are not exempt from tax on other grounds.

d. “Hand tools” are tools which can be held in the hand or hands and which are powered by human effort. Hand tools specifically designed for use in livestock or dairy production are exempt from tax as “equipment.” Mechanical devices that are held in the hand and driven by electricity or some source other than human muscle power are, if otherwise qualified, exempt from tax as “farm machinery.” See subrule 18.48(7), List C, for examples of “hand tools” exempt and not exempt from tax.

e. Directly used in livestock or dairy production. To determine if machinery or equipment is “directly” used in livestock or dairy production, one must first ensure that the machinery or equipment is used during livestock or dairy production and not before that process has begun or after it has ended. Subrule 18.48(1), paragraph “g,” describes when livestock or dairy production begins and ends. If the machinery or equipment is used in livestock or dairy production, to be “directly” so used, that use must constitute an integral and essential part of production as distinguished from a use in production which is incidental, merely convenient to or remote from production. The fact that machinery or equipment is essential or necessary to livestock or dairy production does not mean that it is also “directly” used in production. Machinery or equipment may be necessary to livestock or dairy production but so remote from it that it is not directly used in that production.

(1) In determining whether machinery or equipment is used directly, consideration should be given to the following factors:

1. The physical proximity of the machinery or equipment to other machinery or equipment whose direct use is unarguable. The closer the machinery or equipment whose direct use is questioned is to

the machinery or equipment whose direct use is not questioned, the more likely it is that the former is directly used in livestock or dairy production.

2. The proximity in time of the use of machinery or equipment whose direct use is questionable to the use of machinery whose direct use is not questioned. The closer in time the use, the more likely that the questioned machinery or equipment's use is direct rather than remote.

3. The active causal relationship between the use of the machinery or equipment in question and livestock or dairy production. The fewer intervening causes between the use of the machinery or equipment and the production of the product, the more likely it is that the machinery or equipment is directly used in production.

(2) The following are examples of machinery and equipment directly used in livestock or dairy production:

1. Machinery and equipment used to transport or limit the movement of livestock and dairy animals (e.g., electric fence equipment, head gates, and loading chutes).

2. Machinery and equipment used in the conception, birth, feeding, and watering of livestock or dairy animals (e.g., artificial insemination equipment, portable farrowing pens, feed carts, and automatic watering equipment).

3. Machinery and equipment used to maintain healthful or sanitary conditions in the immediate area where livestock are kept (e.g., manure gutter cleaners, automatic cattle oilers, fans, and heaters if not real property).

4. Machinery or equipment used to test or inspect livestock or dairy animals during production.

(3) The following are nonexclusive examples of machinery or equipment which would not be directly used in livestock or dairy production.

1. Machinery or equipment used to assemble, maintain, or repair other machinery or equipment directly used in livestock or dairy production (e.g., welders, paint sprayers, and lubricators).

2. Machinery used in farm management, administration, advertising, or selling (e.g., a recordkeeping computer, calculating machine, office safe, telephone, books, and farm magazines).

3. Machinery or equipment used in the exhibit of livestock or dairy animals (e.g., blankets, halters, prods, leads, and harnesses).

4. Machinery or equipment used in safety or fire prevention, even though the machinery or equipment is required by law.

5. Machinery or equipment for employee or personal use. Machinery or equipment used for the personal comfort, convenience, or use by a farmer, the farmer's family or employees, or persons associated with the farmer are not exempt from tax. Examples of such machinery and equipment include the following: beds, mattresses, blankets, tableware, stoves, refrigerators, and other equipment used in conjunction with the operation of a farm home or of a migrant labor camp, or other facilities for farm employees.

6. Machinery and equipment used for heating, cooling, ventilation, and illumination of farm buildings generally rather than specifically in the immediate area where livestock are kept.

7. Vehicles subject to registration.

f. "Primarily" used in livestock or dairy production. Machinery or equipment is "primarily used in livestock or dairy production" if of the total time that unit of machinery or equipment is used, more than 50 percent of the time is in livestock or dairy production. If a unit of machinery or equipment is used more than 50 percent of the time for production and the balance of time for other business purposes, the exemption applies. If a unit of equipment is used 50 percent or more of the time for business purposes other than livestock or dairy production, the exemption does not apply. Any unit of machinery or equipment used more than 50 percent of the time directly in livestock or dairy production is subject to the exemption.

g. Beginning and end of livestock or dairy production. Livestock or dairy production begins with the purchase or breeding of livestock or dairy animals. Livestock and dairy production ceases when an animal or the product of an animal's body (e.g., wool or milk) has been transported to the point where it will be sold by the farmer or processed.

h. Farm machinery and equipment means machinery and equipment specifically designed for use in livestock and dairy production or equipment and machinery not specifically designed for this use but which are directly and primarily used in livestock or dairy production except for common or ordinary hand tools. See 18.48(1) “*d*” for a definition of “hand tools.”

EXAMPLE. Farmer Jones raises livestock and fans must be used to cool the animals. Farmer Jones buys fans designed for use in a residence which he uses directly and solely to cool the livestock. The exemption applies.

i. “Self-propelled implement” has the same meaning as in 701—subrule 17.9(5), paragraph “*c*” where the term is defined to mean an implement which is capable of movement from one place to another under its own power. The term self-propelled implement includes but is not limited to the following items: skidloaders and tractors; and the following machinery if capable of movement under its own power: combines, corn pickers, fertilizer spreaders, hay conditioners/windrowers, sprayers, and bean buggies.

j. Implements customarily drawn or attached to self-propelled implements. The following is a nonexclusive, representative list of implements which are customarily drawn or attached to self-propelled implements: augers, balers, blowers, combines, conveyers, cultivators, disks, drags, dryers (portable), farm wagons, feeder wagons, fertilizer spreaders, front- and rear-end loaders, harrows, hay loaders, mowers and rakes, husking machines, manure spreaders, planters, plows, posthole diggers, rotary blade mowers, rotary hoes, sprayers and tanks, and tillage equipment.

k. The term “grain dryer” includes the heater and the blower necessary to force the warmed air into a grain storage bin. It does not include equipment used in grain storage or movement such as augers and spreaders or any other equipment that is not a grain dryer. Equipment other than a grain dryer which is used in grain drying may be exempt or subject to refund if the equipment is a self-propelled implement or customarily drawn or attached to a self-propelled implement.

l. The term “replacement parts essential to any repair or reconstruction necessary to farm machinery or equipment’s exempt use in the production of agricultural products” does not include attachments and accessories not essential to the operation of the machinery or equipment itself (except when sold as part of the assembled unit) such as cigarette lighters, radios, canopies, air conditioning units, cabs, deluxe seats, and tools or utility boxes.

18.48(2) *Right of refund for farm machinery and equipment used in livestock or dairy production, basic requirements.* Rescinded IAB 10/13/93, effective 11/17/93.

18.48(3) *Treatment of replacement parts.* Rescinded IAB 10/13/93, effective 11/17/93.

18.48(4) *Packing material used in agricultural, livestock, or dairy production.* For sales occurring on or after July 1, 1996, the gross receipts from the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock, or dairy production are not subject to sales tax. This exemption also applies to producers of ornamental, flowering, or vegetable plants in commercial greenhouses or other places which sell such items in the ordinary course of business since that activity is considered to be agricultural.

18.48(5) Rescinded IAB 11/20/96, effective 12/25/96.

18.48(6) *Auxiliary attachments exemption.* On and after July 1, 1995, sales of auxiliary attachments which improve the performance, safety, operation, or efficiency of machinery or equipment are exempt from tax. Sales of replacement parts for these auxiliary attachments are also exempt on and after that date.

18.48(7) *Lists.* Lists (representative but not all-inclusive) of tangible personal property for which sales or use tax paid is or is not refundable.

LIST A. Property Used in Livestock and Dairy
Production Which is Usually Real Property. See
18.48(1) “*c*”(1). Its sale is usually taxable.

barn ventilators*	livestock feeders*
conveyers*	silos
farrowing crates*	specialized flooring*
fence posts	sprinklers
fencing wire	stanchions
furnaces*	watering tanks*
gestation stalls*	ventilators*

*These items also appear in List D. Tax paid on their sale can be refundable or their sale exempt if the items are not real property.

LIST B. Taxable Farm Supplies
Which Are Not Machinery or Equipment

burlap*	lubricants
disposable hypodermic syringes	marking chalk
ear tags	packages for one-time use
hog rings	

*Burlap is exempt when used in the form of a bag, container, wrap or other receptacle or packaging material.

LIST C. Hand Tools—Taxable and Nontaxable

axes	lanterns
brooms	milk cans*
buckets	mops
cleaning brushes	paintbrushes
dehorner (nonelectric)*	pliers
garden hoses	scrapers
grease guns	screwdrivers
hammers	shovels
hay hooks*	wheelbarrows
hog ringers*	wrenches
lamps	

*Hand tools specially designed for use in livestock or dairy production are equipment. Tax paid on the sale or use of these hand tools is refundable.

LIST D. Farm Machinery and Equipment Directly and
Primarily Used in Livestock or Dairy Production.
Tax Paid is Usually Refundable or the Sale Exempt.

artificial insemination equipment	gates*
augers*	grain augers
automatic feeding systems*	head gates
bulk feeding tanks*	heating pads and lamps
bulk milk coolers	hog feeders*
bulk milk tanks	hypodermic syringes and needles, nondisposable
cattle weaners and feeders	livestock feeding, watering and handling equipment*
cattle currying and oiling machines	loading chutes*
cattle feeders*	LP gas tanks
conveyers*	manure handling equipment*
dehorner, electric	milk coolers
electric fence equipment	milk strainers
fans*	milking machines
farrowing crates, houses and stalls*	refrigerators used to cool raw milk
feed bins*	silo unloaders
feed carts	specialized flooring*
feed elevators*	space heaters
feed grinders	sprayers
feed tanks*	squeeze chutes*
feeders	vacuum coolers
foggers	ventilators*
furnaces*	

*If not real property. See 18.48(1) "c"(1).

18.48(8) *Seller's and purchaser's liability for sales tax.* The seller shall be relieved of sales tax liability if the seller takes from the purchaser an exemption certificate stating that the purchase is of machinery or equipment meeting the requirements of subrule 18.48(4). An exemption certificate can take the form of a stamp imprinted onto one of the documents of sale. If items purchased tax-free pursuant to an exemption certificate are used or disposed of by the purchaser in a nonexempt manner, the purchaser is solely liable for the taxes and shall remit the tax directly to the department.

This rule is intended to implement Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.

701—18.49(422,423) Aircraft sales, rental, component parts, and services exemptions prior to, on, and after July 1, 1999.

18.49(1) Prior to July 1, 1999, sales in Iowa of aircraft subject to registration were subject to sales tax. On and after July 1, 1999, sales of aircraft in Iowa are subject to Iowa use tax rather than Iowa sales tax. See rule 701—31.6(423). Also, on and after that date, the use tax imposed on sales of aircraft in Iowa is collected by the Iowa department of transportation at the time of the aircraft's registration. Sales of certain aircraft parts in Iowa, the performance of taxable services in Iowa on or in connection with the repair, remodeling, or maintenance of aircraft, and the rental of aircraft in Iowa remain subject to Iowa sales tax on and after July 1, 1999. See subrule 18.49(3).

18.49(2) For the purposes of this subrule only, an "aircraft" is any contrivance known or hereafter invented which is designed for navigation of or flight in the air and is used in a scheduled interstate Federal Aviation Administration certified air carrier operation.

a. Exempt aircraft sales. As of July 1, 1988, and up to and including June 30, 1999, gross receipts from the sale of aircraft are exempt from tax.

b. Exempt rental of aircraft. Effective May 1, 1995, and retroactive to July 1, 1988, the taxable rental (see 701—26.74(422,423)) of aircraft, as defined in the introductory paragraph of this subrule, is exempt from tax.

c. Exempt sale or rental of aircraft parts. Effective May 1, 1995, and retroactive to July 1, 1988, gross receipts from the sale or rental of tangible personal property permanently affixed to any aircraft as a component part of that aircraft are exempt from tax. The term "component parts" includes, but is not limited to, repair or replacement parts and materials.

d. Exempt performance of services. Effective May 1, 1995, and retroactive to July 1, 1988, gross receipts from the rendering, furnishing, or performing of services in connection with the repair, remodeling, or maintenance of aircraft (including aircraft engines and component materials or parts) are exempt from tax.

18.49(3) For the purposes of this subrule only, an "aircraft" is any aircraft used in a nonscheduled interstate Federal Aviation Administration certified air carrier operation conducted under 14 CFR ch. 1, pt. 135. On and after July 1, 1998, the gross receipts from the sale or rental of tangible personal property permanently affixed or permanently attached as a component part of these aircraft, including but not limited to repair or replacement materials or parts, are exempt from tax. Also exempt, on and after that date, are the gross receipts from the performance of any service used for aircraft repair, remodeling, or maintenance when the service is performed on an aircraft, aircraft engine, or aircraft component material or part exempt under this subrule. Gross receipts from the sale or rental of aircraft are not exempt from tax under this subrule.

18.49(4) For the purposes of this subrule only, an "aircraft" is any contrivance known or hereafter invented which is designed for navigation of or flight in the air. On and after July 1, 1998, and up to and including June 30, 1999, the gross receipts from the sale of an aircraft to an aircraft dealer who rents or leases the aircraft to another are exempt from tax if all of the following circumstances exist:

- a.* The aircraft is kept in the inventory of the dealer for sale at all times.
- b.* The dealer reserves the right to immediately take the aircraft from the renter or lessee when a buyer is found.
- c.* The renter or lessee is aware that the dealer will immediately take the aircraft when a buyer is found.

As soon as an aircraft, the sale of which is exempt under this subrule, is used for any purpose other than leasing or renting, or the conditions set out in paragraphs “a,” “b,” and “c” are not continuously met, the dealer claiming the exemption is liable for the tax which would have been due but for the exemption set out in this subrule. Tax will be computed on the original purchase price paid by the dealer.

See rule 701—32.13(423) for a description of the manner in which transactions described in this subrule are exempted from tax on and after July 1, 1999.

This rule is intended to implement Iowa Code section 422.45, subsections 38, 38A, 38B and 38C and Iowa Code section 423.2 as amended by 1999 Iowa Acts, chapter 168.

701—18.50(422,423) Property used by a lending organization. On and after July 1, 1988, the gross receipts from the sale of tangible personal property to a nonprofit organization organized for the purpose of lending the tangible personal property to the general public for use by the public for nonprofit purposes are exempt from tax. The exemption contained in this rule is applicable to tangible personal property only, and not to taxable services. It is applicable to the sale of that property and not to its rental to a nonprofit organization. Finally, the exemption is applicable only to property purchased by a nonprofit organization for subsequent rental to the general public. The exemption is not applicable to other property (e.g., office equipment) which the nonprofit organization might need for its ongoing existence.

This rule is intended to implement Iowa Code section 422.45(36).

701—18.51(422,423) Sales to nonprofit legal aid organizations. On and after July 1, 1988, the gross receipts from the sale or rental of tangible personal property or from services performed, rendered, or furnished to a nonprofit legal aid organization are exempt from tax.

This rule is intended to implement Iowa Code subsection 422.45(37).

701—18.52(422,423) Irrigation equipment used in farming operations. On and after July 1, 1989, the gross receipts from the sale or rental of irrigation equipment used in farming operations are exempt from tax. The term “irrigation equipment” includes, but is not limited to, circle irrigation systems and trickle irrigation systems. The term “farming operations” has the same meaning as the term “agricultural production” set out in 701—subrule 17.9(3), paragraph “a,” and as further characterized in 18.44(2) “a.”

Effective May 18, 2001, and retroactive to April 1, 1995, the gross receipts from the sale or rental of irrigation equipment, as defined above, whether installed above or below ground are exempt from tax as long as the equipment is sold or rented by a contractor or farmer and the equipment is primarily used in agricultural operations.

Contractors or farmers entitled to the exemption set forth in the previous paragraph may apply for a refund of taxes, interest or penalties paid on the sale or rental of qualifying irrigation equipment for transactions that occurred between April 1, 1995, and May 18, 2001. To be eligible for refund, refund claims must be filed with the department prior to October 1, 2001. Refund claims are limited to \$25,000 in the aggregate and will not be allowed if not timely filed. If the amount of refund claims totals more than \$25,000 in the aggregate, the department will prorate the \$25,000 among all claimants in relation to the amounts of the claimants’ valid claims.

This rule is intended to implement Iowa Code section 422.45 and 2001 Iowa Acts, House File 723.

701—18.53(422,423) Sales to persons engaged in the consumer rental purchase business. On and after July 1, 1989, the gross receipts from the sale of tangible personal property, except vehicles subject to registration, to persons regularly engaged in the consumer purchase business are exempt from tax if the property (1) is sold for the purpose of utilization in a transaction involving a “consumer rental purchase agreement” as defined in Iowa Code subsection 537.3604(8), and (2) the gross receipts from the consumer rental of the property are subject to Iowa sales or use tax.

If property exempt under this rule is made use of for any purpose other than a consumer rental purchase, the person claiming the exemption is liable for the tax that would have been due had the exemption not existed. The tax shall be computed on the original purchase price to the person claiming

the exemption. The aggregate of the tax paid on the consumer rental purchase of the property, not exceeding the amount of sales or use tax owed, shall be credited against the tax.

This rule is intended to implement Iowa Code section 422.45(18).

701—18.54(422,423) Sales of advertising material. On and after July 1, 1990, gross receipts from the sales of advertising material to any person in Iowa are exempt from tax if that person, or any agent of that person, will, after the sale, send that advertising material outside of Iowa and subsequent sole use of that material will be outside this state.

For the purposes of this rule “advertising material” is tangible personal property only, including paper. “Advertising material” is limited to the following: brochures, catalogs, leaflets, fliers, order forms, return envelopes, floppy discs, CD-ROMs, videotapes, and any similar items of tangible personal property which will be used to promote sales of property or services.

This rule is intended to implement Iowa Code section 422.45.

701—18.55(422,423) Drop shipment sales. A “drop shipment” generally involves two sales transactions and three parties. The first party is a consumer located inside Iowa. The second party is a retailer located outside the state. The third party is a supplier who may be located inside or outside of Iowa. The two sales transactions in question are the sale of property from the supplier to the out-of-state retailer, and the further sale of that property from the out-of-state retailer to the consumer in Iowa.

A “drop shipment sale” occurs when the consumer places an order for the purchase of tangible personal property with the out-of-state retailer. The retailer does not own the property ordered at the same time the consumer’s order is placed. The retailer then purchases the property from the supplier. The supplier in turn ships the property directly to the consumer in Iowa. Under Iowa law the supplier in a drop shipment sale cannot be required to collect tax (either sales or use) from the consumer, even if the requisite “nexus” to require collection exists. See the next to last paragraph of this rule for a characterization of “nexus.” The supplier transfers possession of the goods to the consumer; however, transfer of possession alone has never been held to be a “sale” for the purposes of Iowa sales and use tax law. *Sturtz v. Iowa Department of Revenue*, 373 N.W.2d 131 (Iowa 1985) and *Cedar Valley Leasing v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979).

With reference to drop shipment sales: If delivery of the goods under the contract for sale has occurred outside of Iowa, sale of the goods has occurred outside of Iowa. If delivery of the goods under the contract for sale has occurred within Iowa, the sale has occurred here. See *Sturtz* above for more information regarding sales and delivery. If the sale has occurred in Iowa and the retailer possesses the requisite nexus to require it to collect Iowa tax, the retailer is obligated to collect Iowa sales tax upon the “gross receipts” from its sale of the goods to the consumer. If the sale has occurred outside this state, and the retailer possesses the nexus to require it to collect Iowa tax, the retailer is obligated to collect Iowa retailer’s use tax upon the purchase price of the goods. If the retailer does not have nexus sufficient to require it to collect either Iowa sales or Iowa use tax, or if the retailer fails to collect either tax, the consumer is obligated to pay a consumer use tax directly to the department upon the purchase price of the goods. These rules are illustrated in the following examples.

EXAMPLE A: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The Minneapolis retailer contracts with a supplier in Iowa to manufacture and ship the goods to the consumer. The retailer has nexus with Iowa, and delivery under the contract for sale has occurred in this state. In this case, the consumer is obligated to pay and the retailer is obligated to collect Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE B: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The Minnesota retailer contracts with a supplier in Iowa to manufacture and ship the goods to the consumer. The retailer has no nexus with Iowa. Delivery under the contract of sale is in Iowa. Under these circumstances, the consumer is obligated to pay consumer’s use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

EXAMPLE C: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to

the consumer in Des Moines. The retailer has nexus with Iowa, and delivery under the contract for sale occurs in Iowa. Under these circumstances, the consumer is obligated to pay and the retailer is obligated to collect Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE D: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to the consumer in Des Moines. The retailer has nexus with this state; delivery under the contract for sale is in Minnesota. Under the circumstances, the consumer is obligated to pay and the retailer is obligated to collect Iowa retailer's use tax. The supplier is not obligated to collect or pay any Iowa tax.

EXAMPLE E: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier in Minneapolis to manufacture and ship the goods to the consumer in Des Moines. The retailer has no nexus with this state. Delivery can occur in either Minnesota or Iowa. In this example, the consumer is obligated to pay Iowa consumer's use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

EXAMPLE F: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has nexus with Iowa, and delivery under the contract for sale is in Iowa. Under these circumstances, the retailer is obligated to collect and the consumer obligated to pay Iowa sales tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE G: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has nexus with Iowa with delivery in Madison, Wisconsin. Under these circumstances, the retailer is obligated to collect and the consumer obligated to pay Iowa retailer's use tax. The supplier is not obligated to collect any Iowa tax.

EXAMPLE H: A consumer in Des Moines, Iowa, purchases goods from a retailer in Minneapolis, Minnesota. The retailer contracts with a supplier located in Madison, Wisconsin, to ship the goods to the consumer in Des Moines. The retailer has no nexus with Iowa. Delivery under the contract for sale may be in Iowa or Wisconsin. Under these circumstances, the consumer is obligated to pay Iowa consumer's use tax directly to the department. Neither the retailer nor the supplier is obligated to collect any Iowa tax.

As used in these examples, the requirement of "nexus" is discussed in *Good's Furniture House Inc. v. Iowa State Bd. of Tax Review*, 382 N.W.2d 145 (Iowa 1986); cert. den. 479 U.S. 817; *State Tax Commission v. General Trading Co.*, 10 N.W.2d 659, 233 Iowa 877 (1943) affd. 64 S.Ct. 1028, 322 U.S. 335, 88 L.Ed. 1309; and *Nelson v. Sears, Roebuck & Co.*, 292 N.W. 130, 228 Iowa 1273 (1940) reversed 61 S.Ct. 586, 312 U.S. 359, 85 L.Ed. 522, as well as other judicial decisions, and Iowa Code section 422.43(12).

This rule is intended to implement Iowa Code subsections 422.42(2) and 422.42(5).

701—18.56(422,423) Wind energy conversion property. On and after July 1, 1993, the gross receipts from the sale of property used to convert wind energy to electrical energy or the gross receipts from the sale of materials used to manufacture, install, or construct property used to convert wind energy to electrical energy shall be exempt from tax.

For the purposes of this rule, "property used to convert wind energy to electrical energy" means any device which converts wind energy to usable electrical energy including, but not limited to, wind chargers, windmills, wind turbines, pad mount transformers, substations, power lines, and tower equipment.

This rule is intended to implement Iowa Code section 422.45 as amended by 1993 Iowa Acts, chapter 161.

701—18.57(422,423) Exemptions applicable to the production of flowering, ornamental, and vegetable plants. On and after July 1, 1995, the production of flowering, ornamental, or vegetable plants by a grower in a commercial greenhouse or at another location is considered to be a part of agricultural production. The word "plants" does not include trees, shrubs, other woody perennials,

or fungus. The exemption also applies to implements, machinery, equipment, and replacement parts directly and primarily used in the production of flowering, ornamental, or vegetable plants and fuel used for providing heating or cooling for greenhouses or buildings or parts of buildings dedicated to the production of flowering, ornamental, or vegetable plants intended for sale in the ordinary course of business. The following exemptions are applicable to the production of flowering, ornamental, or vegetable plants.

18.57(1) Sales of fertilizer, limestone, herbicides, pesticides, insecticides, plant food, and medication for use in disease, weed, insect control, or other health promotion of flowering, ornamental, or vegetable plants to a commercial greenhouse are exempt from tax. For the purposes of this subrule a virus, bacteria, fungus, or insect which is purchased for use in killing insects or other pests is an “insecticide” or “pesticide.” See rules 701—226.6(423) and 701—17.9(422,423) for more information regarding these exemptions.

18.57(2) Sales of fuel to provide heating or cooling for a greenhouse or building or a part of a building dedicated to the production of flowering, ornamental, or vegetable plants held for sale in the ordinary course of business are exempt from tax. Electricity is a “fuel” for the purposes of this subrule. Fuel used in a plant production building for purposes other than heating or cooling (e.g., lighting) or for purposes other than direct use in plant production (e.g., heating or cooling office space) is not eligible for this exemption. For example, assume that there is a separate meter for electricity used only for heating or cooling. If a greenhouse is used, partially for growing plants and partially for a nonexempt purpose, a proportional exemption from sales tax may be claimed based upon a percentage calculated from a fraction, the numerator of which is the number of square feet of the greenhouse heated or cooled and used for raising plants, and the denominator of which is the number of square feet heated or cooled in the entire greenhouse. It may be necessary to alter this formula (by the use of separate metering, for example) if a greenhouse has a walk-in cooler and the cooler is used directly in plant production. Plant production has ended when a plant has grown to the point that it is of the size or weight at which it will be prepared for shipment to the destination where it will be marketed. Examples of nonexempt purposes for which a portion of a greenhouse might be used include, but are not limited to, portions used for office space, loading docks, storage of property other than plants, housing of heating and cooling equipment and portions used for packaging plants for shipment. See rule 701—15.3(422,423) regarding fuel exemption certificates and subrule 18.48(8) regarding seller’s and purchaser’s liability for sales tax.

18.57(3) Sales of gas, electricity, steam or other tangible personal property for use as a fuel in implements of husbandry used in the production of plants in a commercial greenhouse or elsewhere are exempt from tax. See 701—subrule 17.9(6), paragraph “a,” for a definition of “implements of husbandry.”

18.57(4) Sales of self-propelled implements. Sales of self-propelled implements or implements customarily drawn by or attached to self-propelled implements and replacement parts for the same are exempt from tax if the implements are used directly and primarily in the production of plants in commercial greenhouses or elsewhere. See rule 701—18.44(422,423) for an extensive explanation of this exemption. Implements exempt under this subrule include, but are not limited to, forklifts used to transport pallets of plants; wagons containing sterilized soil and tractors used to pull the same.

18.57(5) Sale of water used in the production of plants is exempt from tax. If water is not separately metered, the grower of plants must determine by use of a percentage that portion which is used for a taxable purpose and that portion which is used for an exempt purpose.

Nonexclusive examples of taxable usage would be rest rooms, sanitation, lawns, and vehicle wash.

18.57(6) For sales occurring on or after July 1, 1996, the gross receipts for the sale of property which is a container, label, carton, pallet, packing case, wrapping, baling wire, twine, bag, bottle, shipping case, or other similar article or receptacle sold for use in agricultural, livestock, or dairy production are not subject to sales tax. This exemption also applies to producers of ornamental, flowering, or vegetable plants in commercial greenhouses or other places which sell such items in the ordinary course of business since that activity is considered to be agricultural. A noninclusive list of containers and packaging materials would include boxes, trays, labels, sleeves, tape, and staples.

18.57(7) Sales of machinery and equipment used in plant production which are not self-propelled or attached to self-propelled machinery and equipment are also exempt from tax. See rule 701—18.48(422,423) for a thorough explanation of this exemption. Listed below are a number of examples of machinery and equipment which are directly and primarily used in plant production. Sales of this machinery and equipment to commercial growers are usually exempt from tax.

- Air-conditioning pads*
- Airflow control tubes
- Atmospheric CO₂ control and monitoring equipment
- Backup generators
- Bins holding sterilized soil
- Control panels = heating and cooling
- Coolers used to chill plants*
- Cooling walls* or membranes
- Equipment used to control water levels for subirrigation
- Fans = cooling and ventilating*
- Floor mesh for controlling weeds
- Germination chambers
- Greenhouse boilers*
- Greenhouse netting or mesh = used for light and heat control
- Greenhouse monorail systems*
- Greenhouse thermometers
- Handcarts used to move plants
- Lighting which provides artificial sunlight
- Overhead heating, lighting and watering systems
- Overhead tracks for holding potted plants*
- Plant tables*
- Plant watering systems*
- Portable buildings used to grow plants*
- Seeding and transplanting machines
- Soil pot and soil flat filling machines
- Steam generators for soil sterilization*
- Warning devices = excess heat or cold
- Watering booms

*If not real property. See 18.48(1) “c”(1).

18.57(8) Miscellaneous exempt and taxable sales. Sales of pots, soil, seeds, bulbs, and “starter plants” for use in plant production are not the sale of machinery or equipment, but can be sales for resale and exempt from tax if the pots and soil are sold with the final product or become the finished product. Sales of portable buildings which will be used to display plants for retail sales are taxable. Finally, sales of whitewash which will be painted on greenhouses to control the amount of sunlight entering those houses are taxable sales of a “supply” rather than exempt sales of equipment. See 18.48(1) “c”(2) relating to “supplies.” See rule 701—18.7(422,423) relating to containers, including packaging cases, shipping cases, wrapping materials, and similar items sold to retailers, and see subrule 18.57(6).

This rule is intended to implement Iowa Code sections 422.42(1), 422.42(4), 422.42(11), 422.45(39) and 422.47(4) and Iowa Code section 422.45 as amended by 1996 Iowa Acts, chapter 1145.
[ARC 4117C, IAB 11/7/18, effective 12/12/18]

701—18.58(422,423) Exempt sales or rentals of computers, industrial machinery and equipment, and exempt sales of fuel and electricity on and after July 1, 1997, but before July 1, 2016. Rescinded ARC 5798C, IAB 7/28/21, effective 9/1/21.

701—18.59(422,423) Exempt sales to nonprofit hospitals. On and after July 1, 1998, the gross receipts from sales or rentals of tangible personal property to and from the rendering, furnishing, or performing of services for a nonprofit hospital licensed under Iowa Code chapter 135B are exempt from tax if the property or service purchased is used in the operation of the hospital. A hospital is not entitled to claim a refund for tax paid by a contractor on the sale or use of tangible personal property or the performance of services in the fulfillment of a written construction contract with the hospital. However, see the circumstances set out below in which sales of goods, wares or merchandise, or taxable services to a hospital for use in the fulfillment of a construction contract, are exempt from Iowa tax.

For the purposes of this rule, the word “hospital” means a place which is devoted primarily to the maintenance and operation of facilities for diagnosis, treatment, or care, over a period exceeding 24 hours, of two or more nonrelated individuals suffering from illness, injury, or a medical condition (such as pregnancy). The word “hospital” includes general hospitals, specialized hospitals (e.g., pediatric, mental, and orthopedic hospitals, and cancer treatment centers), sanatoriums, and other hospitals licensed under Iowa Code chapter 135B. Also included are institutions, places, buildings, or agencies in which any accommodation is primarily maintained, furnished, or offered for the care, over a period exceeding 24 hours, of two or more nonrelated aged or infirm persons requiring or receiving chronic or convalescent care. Excluded from the meaning of the term “hospital” are institutions for well children; day nursery and child care centers; foster boarding homes and houses; homes for handicapped children; homes, houses, or institutions for aged persons which limit their function to providing food, lodging, and provide no medical or nursing care, and house no bedridden person; dispensaries or first-aid stations maintained for the care of employees, students, customers, members of any commercial or industrial plan, educational institution, or convent; freestanding hospice facilities which operate a hospice program in accordance with 42 CFR § 418 and freestanding clinics which do not provide diagnosis, treatment, or care for periods exceeding 24 hours. This list of inclusions and exclusions is not exclusive. For additional information see 481—Chapter 51.

Ordinarily, goods, wares, or merchandise (such as building materials, supplies, and equipment; see rule 701—19.3(422,423) for definitions) which is purchased by a hospital and used by a contractor in the fulfillment of a written contract with the hospital cannot be purchased exempt from Iowa tax. The goods, wares, and merchandise used in the fulfillment of these construction contracts are not used in the “operation” of a hospital but in activities at least one step removed from that operation. See *Polich v. Anderson-Robinson Coal Co.*, 227 Iowa 553, 288 N.W. 650 (1939).

However, for a limited period, the gross receipts from all sales of goods, wares, or merchandise or from services rendered, furnished, or performed are exempt from tax (or a claim for refund may be filed for tax paid) if the tangible personal property or the taxable service is used in the fulfillment of a written construction contract with a hospital and all of the following circumstances exist:

1. Deliveries under contracts of sale of the goods, wares, or merchandise occurred or the taxable services were rendered, furnished, or performed between July 1, 1998, and December 31, 2001, inclusive. A claim for refund may be filed for any tax paid for this period, so long as the claim is filed prior to April 1, 2002, and the requirements of “2” and “3” below are also met. Claims for refunds of tax, interest, or penalty paid for the period of July 1, 1998, to December 31, 2001, are limited to \$25,000 in the aggregate. If the amount of the claimed refunds for this period totals more than \$25,000, the department must prorate the \$25,000 among all claimants in relation to the amounts of the claimants’ valid claims.

2. The written construction contract was entered into prior to December 31, 1999, or bonds to fund the construction were issued prior to December 31, 1999.

3. The property or services were purchased directly by the hospital or by a contractor as an agent of the hospital. For the purposes of this exemption, no hospital can retroactively designate a contractor to be its agent and by this means transform a contractor’s purchases of goods, wares, merchandise, or services into its own. Upon the department’s request, a hospital claiming that a contractor is or has been its purchasing agent must present suitable evidence of a principal-agent relationship between itself and the contractor during any period for which exempt sales or a refund is claimed. The best evidence of a principal and purchasing agent relationship is a written document setting out the terms of the relationship

and the period for which the agency is in effect; however, other evidence, which is the equivalent of a written document in reliability, will be considered by the department when necessary.

This rule is intended to implement Iowa Code Supplement section 422.45 as amended by 2000 Iowa Acts, chapter 1207.

701—18.60(422,423) Exempt sales of gases used in the manufacturing process. Effective May 24, 1999, but retroactive to January 1, 1991, sales of argon and other similar gases to be used in the manufacturing process are exempt from tax. For the purposes of this rule, only inert gases are gases which are similar to argon. An “inert gas” is any gas which is normally chemically inactive. It will not support combustion and cannot be used as either a fuel or as an oxidizer. Argon, nitrogen, carbon dioxide, helium, neon, krypton, and xenon are nonexclusive examples of inert gases. Oxygen, hydrogen, and methane are nonexclusive examples of gases which are not inert. These sales are exempt only if the gas is purchased by a “manufacturer,” for used in “processing,” as those terms are defined in subrule 18.45(1), for the period prior to July 1, 1997, and as those terms are defined in subrule 18.58(1) for the period beginning July 1, 1997.

This rule is intended to implement Iowa Code section 422.45 as amended by 1999 Iowa Acts, chapter 170.

701—18.61(422,423) Exclusion from tax for property delivered by certain media. For the period beginning March 15, 1995, a taxable “sale” of tangible personal property does not occur if the substance of the transaction is delivered to the purchaser digitally, electronically, or by utilizing cable, radio waves, microwaves, satellites, or fiber optics. This exclusion from tax is not applicable to any leasing of tangible personal property, a lease not being a “sale” of tangible personal property for the purposes of Iowa sales and use tax law, *Cedar Valley Leasing, Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979). The exclusion is also not applicable to property delivered by any medium other than those listed above. Sales of items such as artwork, drawings, photographs, music, electronic greeting cards, “canned” software (see subrule 18.34(1)), entertainment properties (e.g., films, concerts, books, and television and radio programs), and all other digitized products delivered as described above are not taxable, except the exclusion does not repeal by implication the tax on the service of providing pay television. See rule 701—26.56(422). If an order for a product is placed by way of any of the media described above but the product ordered is delivered by conventional, physical means, e.g., the U.S. Postal Service or common carrier, sale of the product is not excluded from tax under this rule.

This rule is intended to implement Iowa Code Supplement section 422.43 as amended by 2002 Iowa Acts, Senate File 2321.

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[◇] Two or more ARCs

¹ Effective date of 18.20(5) and 18.20(6) delayed 70 days by the Administrative Rules Review Committee at its meeting held February 10, 1997.

² Amendments to 18.29(7) and 18.58, introductory paragraph, (ARC 2349C, Items 2 and 3) rescinded by 2016 Iowa Acts, House File 2433, section 6, on 3/21/16. Amendments removed and prior language restored IAC Supplement 4/27/16.

³ The definition of “computer” in subparagraph 18.34(1)“b”(1), subrule 18.45(1), and subrule 18.58(1) rescinded by 2020 Iowa Acts, House File 2641, section 97, effective July 1, 2020.

⁴ November 11, 2020, effective date of 18.32 (ARC 5201C) delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held November 10, 2020.

TITLE V
INDIVIDUALCHAPTER 38
ADMINISTRATION

[Prior to 12/17/86, Revenue Department[730]]

701—38.1(422) Definitions.

38.1(1) When the word “*department*” appears herein, the word refers to and is synonymous with the “Iowa department of revenue”; the word “*director*” is the “director of revenue” or the director’s authorized assistants and employees.

The administration of the individual income tax is a responsibility of the department. The department is charged with the administration of the individual income tax, fiduciary tax, withholding of tax and individual estimate declarations, subject always to the rules, regulations and direction of the director.

38.1(2) The term “*computed tax*” means the amount of tax remaining before deductions of the personal exemption credit and other credits in Iowa Code chapter 422, division II, and before the computation of the school district surtax and the emergency medical services income surtax.

38.1(3) The word “*taxpayer*” includes under this division:

- a. Every resident of the state of Iowa.
- b. Every part-year resident of the state of Iowa.
- c. Every estate and trust resident of this state whose income is in whole or in part subject to the state income tax.
- d. Nonresident individuals, estates and trusts (those with a situs outside of Iowa) receiving taxable income from property in Iowa or from business, trade, or profession or occupation carried on in this state.

38.1(4) The term “*fiduciary*” shall mean one who acts in place of or for the benefit of another in accordance with the meaning of the term defined in Iowa Code section 422.4. The term includes, but is not limited to, the executor or administrator of an estate, a trustee, guardian or conservator, or a receiver.

38.1(5) The term “*employer*” means those who have a right to exercise control as to the performance of services as defined in Iowa Code section 422.4.

38.1(6) The term “*employee*” means and includes every individual who is a resident, or who is domiciled in Iowa, or any nonresident, or corporation performing services within the state of Iowa, the performance of which services constitutes, establishes, and determines the relationship between the parties as that of employer and employee. This includes officers of corporations, individuals, including elected officials performing services for the United States government or any agency or instrumentality thereof, or the state of Iowa, or any county, city, municipality or political subdivision thereof.

38.1(7) The term “*wages*” means any remuneration for services performed by an employee for an employer, including the cash value of all such remuneration paid in any medium or form other than cash. Wages have the same meaning as provided by the Internal Revenue Code as made applicable to Iowa income tax.

Wages subject to Iowa income tax withholding consist of all remuneration, whether in cash or other form, paid to an employee for services performed for the employer. For this purpose, the word “wages” includes all types of employee compensation, such as salaries, fees, bonuses, and commissions. It is immaterial whether payments are based on the hour, day, week, month, year or on a piecework or percentage plan.

Wages paid in any form other than money are measured by the fair market value of the goods, lodging, meals, or other consideration given in payment for services.

Where wages are paid in property other than money, the employer should make necessary arrangements to ensure that the tax is available for payment. Vacation allowances and back pay, including retroactive wage increases, are taxed as ordinary wages.

Tips or gratuities paid directly to an employee by a customer and not accounted for to the employer are not subject to withholding. However, the recipients must include them in their personal income tax returns.

Amounts paid specifically, either as advances or reimbursements, for traveling or other bona fide ordinary and necessary expenses incurred or reasonably expected to be incurred in the business of the employer are not wages and are not subject to these taxes. Traveling and other reimbursed expenses must be identified either by making a separate payment or by specifically indicating the separate amounts where both wages and expense allowance are combined in a single payment.

Wages are to be considered as paid when they are actually paid or when they are constructively paid, that is, when they are credited to the account of, or set apart for the wage earner so that they may be drawn upon by the wage earner at any time, although not then actually reduced to possession.

38.1(8) The term “*responsible party*” shall have the same meaning as withholding agent as defined in Iowa Code section 422.4. A withholding agent includes an officer or employee of a corporation or association, or a member or employee of a partnership, who has the responsibility to perform acts covered by Iowa Code section 422.16. As of July 1, 1993, withholding agent also includes a member or a manager of a limited liability company who has the responsibility to perform acts covered by Iowa Code section 422.16 as amended by 1994 Iowa Acts, Senate File 2057. An individual who is a “responsible party” by law cannot shift that responsibility to someone else by attempting to delegate the responsibility to another corporate officer or employee.

Every business which is an employer must have some person who has the duty of withholding and paying those taxes which the law requires an employer to withhold and pay. There may be more than one person, but there must be at least one. The fact that any individual may not have been the only responsible person would not excuse that person from the responsibility of paying withholding taxes. Any withholding agent as defined in this subrule, who knowingly violates the statutory provisions of Iowa Code section 422.16, will be held liable for the tax due: *Pacific National Insurance Co. v. United States*, 1970, 9th Cir., 422 F.2d 26, cert. denied, 398 U.S. 937; *R. E. Dougherty v. United States*, 1971, 327 F. Supp. 202; *Gefen v. United States*, 5th Cir. 1968, 400 F.2d 476.

38.1(9) *Domicile*. Rescinded IAB 5/10/95, effective 6/14/95.

This rule is intended to implement Iowa Code sections 422.3, 422.4 and 422.16.

701—38.2(422) Statute of limitations.

38.2(1) *Periods of audit.*

a. The department has three years after a return has been filed or three years after the return became due, including any extensions of time for filing, whichever time is the later, to determine whether any additional tax other than that shown on the return is due and owing. This three-year statute of limitations does not apply in the instances specified in paragraphs “*b*,” “*c*,” “*d*,” “*e*,” “*f*” and “*g*.”

b. If a taxpayer fails to include in the taxpayer’s return items of gross income as defined in the Internal Revenue Code as amended, as will under that Code extend the statute of limitations for federal tax purposes to six years, the correct amount of tax due may be determined by the department within six years from the time the return is filed, or within six years after the return became due, including any extensions of time for filing, whichever time is the later.

c. If a taxpayer files a false or fraudulent return with intent to evade tax, the correct amount of tax due may be determined by the department at any time after the return has been filed.

d. If a taxpayer fails to file a return, the periods of limitations so specified in Iowa Code section 422.25 do not begin to run until the return is filed with the department.

e. While the burden of proof of additional tax owing under the six-year period or the unlimited period is upon the department, a prima facie case of omission of income, or of making a false or fraudulent return, shall be made upon a showing of a federal audit of the same income, a determination by federal authorities that the taxpayer omitted items of gross income or made a false or fraudulent return, and the payment by the taxpayer of the amount claimed by the federal government to be the correct tax or the admission by the taxpayer to the federal government of liability for that amount.

f. In addition to the periods of limitation set forth in paragraph “*a*,” “*b*,” “*c*,” “*d*,” or “*e*,” the department has six months after notification by the taxpayer of the final disposition of any matter between the taxpayer and the Internal Revenue Service with respect to any particular tax year to make an examination and determination. Final disposition of any matter between the taxpayer and

the Internal Revenue Service triggers the extension of the statute of limitations for the department to make an examination and determination, and the extension runs until six months after the department receives notification and a copy of the federal document showing the final disposition or final federal adjustments from the taxpayer. *Van Dyke v. Iowa Department of Revenue and Finance*, 547 N.W.2d 1. This examination and determination is limited to those matters between the taxpayer and the Internal Revenue Service which affect Iowa taxable income. *Kelly-Springfield Tire Co. v. Iowa State Board of Tax Review*, 414 N.W.2d 113 (Iowa 1987). The notification shall be in writing in any form sufficient to inform the department of final disposition, and attached to the notification shall be a photo reproduction or carbon copy of the federal document which shows the final disposition and any schedules necessary to explain the federal adjustments. The notification and copy of the federal document shall be mailed, under separate cover, to the Examination Section, Compliance Division, P.O. Box 10456, Des Moines, Iowa 50306. Any notification and copy of the federal document which is included in, made a part of, or mailed with a current year Iowa individual income tax return will not be considered as proper notification for the purposes of beginning the running of the six-month period.

g. In lieu of the period of limitation for any prior year for which an overpayment of tax or an elimination or reduction of an underpayment of tax due for that prior year results from the carryback to such prior year of a net operating loss or net capital loss, the period shall be the period of limitation for the taxable year of the net operating loss or net capital loss which results in such carryback.

38.2(2) Waiver of statute of limitations. When the taxpayer and the department enter into an agreement to extend the period of limitation, interest continues to accrue on any deficiency or overpayment during the period of the waiver. The taxpayer may claim a refund during the period of the waiver.

38.2(3) Amended returns filed within 60 days of the expiration of the statute of limitations for assessment. If a taxpayer files an amended return on or after April 1, 1995, within 60 days prior to the expiration of the statute of limitations for assessment, the department has 60 days from the date the amended return is received to issue an assessment for applicable tax, interest, or penalty.

This rule is intended to implement Iowa Code section 422.25.

701—38.3(422) Retention of records.

38.3(1) Every individual subject to the tax imposed by Iowa Code section 422.5 (whether or not the individual incurs liability for the tax) and every withholding agent subject to the provisions of Iowa Code section 422.16 shall retain those books and records as required by Section 6001 of the Internal Revenue Code and federal income tax regulation 1.6001-1(e) including the federal income tax return and all supporting federal schedules. For taxpayers using an electronic data interchange process or technology also see 701—subrule 11.4(4).

38.3(2) In addition, records relating to other deductions or additions to federal adjusted income and Iowa tax credits shall be retained so long as the contents may be material in the administration of the Iowa Code under the statutes of limitations for audit specified in Iowa Code section 422.25.

This rule is intended to implement Iowa Code sections 422.25 and 422.70.

[ARC 9104B, IAB 9/22/10, effective 10/27/10]

701—38.4(422) Authority for deductions. Whether and to what extent deductions shall be allowed depends upon specific legislative acts, and only where there is a clear provision can any particular deduction be allowed. Therefore, a deduction will be allowed only if the taxpayer can establish the validity and correctness of such deduction.

This rule is intended to implement Iowa Code sections 422.7 and 422.9.

701—38.5(422) Jeopardy assessments.

38.5(1) A jeopardy assessment may be made in a case where a return has been filed, and the director believes for any reason that collection of the tax will be jeopardized by delay; or in a case where a taxpayer fails to file a return, whether or not formally called upon to do so, in which case the department

is authorized to estimate the income of the taxpayer upon the basis of available information, and to add penalty and interest.

38.5(2) A jeopardy assessment is due and payable when the notice of the assessment is served upon the taxpayer. Proceedings to enforce the payment of the assessment by seizure or sale of any property of the taxpayer may be instituted immediately.

This rule is intended to implement Iowa Code section 422.30.

701—38.6(422) Information deemed confidential. Iowa Code sections 422.20 and 422.72 apply generally to the director, deputies, auditors, agents, present or former officers and employees of the department. Disclosure of information from a taxpayer's filed return or report or other confidential state information by department of revenue personnel to a third person is prohibited under the above sections. Other persons having acquired information disclosed in a taxpayer's filed return or report or other confidential state information will be bound by the same rules of secrecy under these sections as any member of the department and will be subject to the same penalties for violations as provided by law. See rule 701—6.3(17A).

This rule is intended to implement Iowa Code sections 422.16, 422.20, and 422.72.

701—38.7(422) Power of attorney. For information regarding power of attorney, see rule 701—7.34(421).

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—38.8(422) Delegations to audit and examine. Pursuant to statutory authority, the director delegates to authorized assistants and employees the power to examine returns and make audits; and to determine the correct amount of tax due, subject to review by or appeal to the director.

This rule is intended to implement Iowa Code section 422.70.

701—38.9(422) Bonding procedure. The director may, when necessary and advisable in order to secure the collection of the tax required to be deducted and withheld or the amount actually deducted, whichever is greater, require an employer or withholding agent to file with the director a bond issued by a surety company authorized to conduct business in Iowa and approved by the insurance commissioner as to solvency and responsibility in an amount the director may fix, or in lieu of bond, securities approved by the director in an amount the director may prescribe and keep in the custody of the department. Pursuant to the statutory authorization in Iowa Code section 422.16, the director has determined that the following procedures will be instituted with regard to bonds. However, the bonding procedures were applicable only to nonresident employers or withholding agents for withholding taxes due prior to January 1, 1987. The penalty for failure of a withholding agent to file a bond, described in subrule 38.9(4) applies to taxes required to be withheld on or after January 1, 1990.

38.9(1) When required.

a. New applications by withholding agents. A new withholding agent applicant will be requested to post a bond or security if (1) it is determined upon a complete investigation of the applicant's financial status that the applicant would be unable to timely remit the tax, or (2) the new applicant held a withholding agent's identification number for a prior business and the remittance record of the tax under the prior identification number falls within one of the conditions in paragraph "b" below, or (3) the department experienced collection problems while the applicant was engaged in business under the prior identification number.

b. Existing withholding agents. Existing withholding agents shall be requested to post a bond or security when they have had two or more delinquencies in remitting the withholding tax during the last 24 months if filing returns on a quarterly basis or have had four or more delinquencies during the last 24 months if filing returns on a monthly basis. The simultaneous late filing of the return and the late payment of the tax will count as one delinquency. However, the late filing of the return or the late payment of the tax will not count as a delinquency if the withholding agent can satisfy one of the conditions set forth in Iowa Code section 421.27.

c. Waiver of bond. If a withholding agent has been requested to post a bond or security or if a withholding agent applicant has been requested to post a bond or security, upon the filing of the bond or security, if the withholding agent maintains a good filing record for a period of two years, the withholding agent may request that the department waive the continued bond or security requirement.

38.9(2) Type of security or bond. When it is determined that a withholding agent or withholding agent applicant is required to post collateral to secure the collection of the withholding tax, the following types of collateral will be considered as sufficient: surety bonds, securities or certificates of deposit. When the withholding agent is a corporation, an officer or employee of the corporation may assume personal liability as security for the payment of the withholding tax. The officer or employee will be evaluated as provided in 38.9(1) "a" as if the officer or employee applied as the withholding agent as an individual.

38.9(3) Amount of bond or security. When it is determined that a withholding agent or withholding agent applicant is required to post a bond or securities, the following guidelines will be used to determine the amount of the bond, unless the facts warrant a greater amount: If the withholding agent or applicant will be or is a monthly depositor, a bond or securities in an amount sufficient to cover five months' withholding tax liability will be required. If the applicant or withholding agent will be or is a quarterly filer, the bond or securities which will be required is an amount sufficient to cover nine months or three quarters of tax liability.

38.9(4) Penalty for failure of a withholding agent to file bond. If the withholding agent is requested by the department to file a bond to secure collection of the state withholding tax and fails to file the bond, the withholding agent is subject to a penalty. The penalty for failure to file a bond is 15 percent of the tax the withholding agent is required to withhold on an annual basis. However, the penalty cannot exceed \$5000.

This rule is intended to implement Iowa Code section 422.16.

701—38.10(422) Indexation. Iowa Code section 422.5 provides for the adjustment of the tax brackets by a cumulative inflation factor to be determined by the director. The requirement that provided that the state general fund balance on June 30 of the prior calendar year had to be \$60 million or more before there was indexation of the tax rate brackets for the current year was repealed for tax years beginning on or after January 1, 1996.

This rule is intended to implement Iowa Code sections 422.4 and 422.21.
[ARC 1303C, IAB 2/5/14, effective 3/12/14]

701—38.11(422) Appeals of notices of assessment and notices of denial of taxpayer's refund claims. A taxpayer may appeal to the director at any time within 60 days from the date of the notice of assessment of tax, additional tax, interest, or penalties. For assessments issued on or after January 1, 1995, if a taxpayer fails to timely appeal a notice of assessment, the taxpayer may pay the entire assessment and file a refund claim within the period provided by law for filing such claims. In addition, a taxpayer may appeal to the director at any time within 60 days from the date of notice from the department denying changes in filing methods, denying refund claims, or denying portions of refund claims. See rule 701—7.8(17A) for information on filing appeals or protests.

This rule is intended to implement Iowa Code sections 421.10 and 422.28.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—38.12(422) Indexation of the optional standard deduction for inflation. Effective for tax years beginning on or after January 1, 1990, the optional standard deduction is indexed or increased by the cumulative standard deduction factor computed by the department of revenue. The cumulative standard deduction factor is the product of the annual standard deduction factor for the 1989 calendar year and all standard deduction factors for subsequent annual calendar years. The annual standard deduction factor is an index, to be determined by the department of revenue by October 15 of the calendar year, which reflects the purchasing power of the dollar as a result of inflation during the fiscal year ending in that calendar year preceding the calendar year for which the annual standard deduction factor is to apply. For tax years beginning on or after January 1, 1996, the department shall use the annual percentage change,

but not less than 0 percent, in the gross domestic product price deflator computed for the second quarter of the calendar year by the Bureau of Economic Analysis of the United States Department of Commerce and shall add all of that percentage change to 100 percent, rounded to the nearest one-tenth of 1 percent. The annual standard deduction factor shall not be less than 100 percent.

This rule is intended to implement Iowa Code section 422.4.
[ARC 7761B, IAB 5/6/09, effective 6/10/09]

701—38.13(422) Reciprocal tax agreements. Effective for tax years beginning on or after January 1, 2002, the department of revenue may, when the action has been approved by the general assembly and the governor, and when it is cost-efficient, administratively feasible, and of mutual benefit to Iowa and another state, enter into a reciprocal tax agreement with a tax administration agency of the other state. Under this agreement, income earned from personal services in Iowa by residents of the other state will be exempt from Iowa income tax if the other state provides an identical exemption from its state income tax for income earned in the other state from personal services by Iowa residents. For purposes of this rule, “income earned from personal services” includes wages, salaries, commissions, tips, deferred compensation, pensions, and annuities which were earned from personal services in Iowa by a resident of another state that had a reciprocal tax agreement with Iowa at the time the wages, salaries, commissions, tips, deferred compensation, pensions, or annuities were earned. See rule 701—40.45(422) for the treatment of deferred compensation, pensions, or annuities received by a nonresident of Iowa related to the documented retirement of a participant in a deferred compensation plan, a pensioner or an annuitant. The provisions of rule 701—40.45(422) supersede the definition of “income earned from personal services” under any reciprocal agreement as it relates to deferred compensation, pensions, or annuities.

38.13(1) Reciprocal tax agreement with Illinois. Pursuant to the authority of Iowa Code subsection 422.8(5), the department of revenue entered into a reciprocal tax agreement with tax administration officials of Illinois in November 1972 which went into effect for taxable years which began after December 31, 1972. The Iowa-Illinois reciprocal tax agreement cannot be terminated by the Iowa department of revenue unless the termination is authorized by a constitutional majority of each house of the general assembly and is approved by the governor. The Iowa-Illinois reciprocal tax agreement includes the following terms:

- a. No Illinois or Iowa employer is required to withhold Illinois income tax from compensation paid to an Iowa resident for personal services in Illinois.
- b. No Illinois or Iowa employer is required to withhold Iowa income tax from compensation paid to an Illinois resident for personal services in Iowa.
- c. Every Iowa employer who is subject to the jurisdiction of Illinois is liable to the state of Illinois for withholding of Illinois income tax from compensation paid to Illinois residents.
- d. Every Illinois employer who is subject to the jurisdiction of Iowa is liable to the state of Iowa for the withholding of Iowa income tax from compensation paid to Iowa residents.
- e. The Illinois department of revenue will encourage Illinois employers who are not subject to the jurisdiction of Iowa to withhold and remit Iowa income tax from wages paid to Iowa residents employed in Illinois.
- f. The Iowa department of revenue will encourage Iowa employers who are not subject to the jurisdiction of Illinois to withhold and remit Illinois income tax from compensation paid to Illinois residents from employment in Iowa.
- g. For purposes of the agreement, “compensation” means wages, salaries, commissions, tips, deferred compensation, pensions, and annuities and any other remuneration paid for personal services. In the case of deferred compensation, pensions, and annuities, those incomes are deemed to have been earned at the time of employment. Therefore, if an Illinois resident receives a pension or annuity from employment in Iowa at the time the reciprocal agreement was in effect, the pension or annuity income is not taxable to Iowa since it is “compensation” covered by the reciprocal agreement. See rule 701—40.45(422) for the treatment of deferred compensation, pensions, or annuities received by an Illinois resident related to the documented retirement of a participant in a deferred compensation

plan, a pensioner or an annuitant. The provisions of rule 701—40.45(422) supersede the definition of “compensation” under the reciprocal agreement with Illinois. “Compensation” does not include unemployment compensation benefits which an Illinois resident receives due to employment in Iowa.

h. No Iowa resident is required to pay Illinois income tax or file an Illinois return from compensation paid from personal services in Illinois.

i. No Illinois resident is required to pay Iowa income tax or to file an Iowa return on compensation for personal services in Iowa.

j. For purposes of the agreement, the term “Iowa resident” means an individual who is a resident under the laws of the state of Iowa, and the term “Illinois resident” means an individual who is a resident as defined in the Illinois Income Tax Act.

38.13(2) *Reciprocal tax agreements with states other than Illinois.* The Iowa department of revenue has not entered into reciprocal tax agreements with any state except the state of Illinois. See subrule 38.13(1).

This rule is intended to implement Iowa Code section 422.8 as amended by 2002 Iowa Acts, House File 2116, and section 422.15.

[ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—38.14(422) Information returns for reporting income payments to the department of revenue. Effective January 1, 1993, every person, every corporation, or agent of a person or corporation, lessees or mortgagors of real or personal property, fiduciaries, employers, and all officers and employees of the state or of any political subdivision of the state, having control, receipt, custody, or disposal of any of the income items described in subrule 38.14(1), shall file information returns with the department of revenue by the last day of February following the end of the year in which the payments were made. For purposes of this rule, “every person” is every individual who is a resident of this state. For purposes of this rule, “every corporation” includes all corporations that have a place of business in this state.

38.14(1) *Incomes to be included in information returns.* The entities described in rule 701—38.14(422) are required to file information returns to the department of revenue on income payments of interest (other than interest coupons payable to the bearer), rents, salaries, wages, premiums, annuities, compensation, remunerations, emoluments, unemployment compensation, royalties, patronage dividends, or other fixed or determinable annual or periodic gains, profits, and income to the extent that the amount of income is great enough so that an information return on the income is required to be filed with the Internal Revenue Service (IRS) under provisions of the Internal Revenue Code. However, no reporting is required for payments of deferred compensation, pensions, and annuities to nonresidents of Iowa. In addition, no reporting is required for any type of income payment where information on the income payment is available to the department from the Internal Revenue Service.

38.14(2) *Information on income payments available from the Internal Revenue Service.* The department can obtain information from the Internal Revenue Service on many income payments made to individuals in the tax year. The following is a list of federal reporting forms and the types of information available on those forms from the Internal Revenue Service for residents of Iowa:

- a.* 1065 K-1.
1. Dividends.
 2. Interest.
 3. Tax withheld.
 4. Royalties.
 5. Ordinary income or (loss).
 6. Real estate income or (loss).
 7. Other rental income or (loss).
 8. Other portfolio income or (loss).
 9. Guaranteed payments.

- b.* K-1 1041.
 - 1. Dividends.
 - 2. Interest.
 - 3. Other taxable income or (loss).
 - 4. Tax withheld.

- c.* K-1 1120-S.
 - 1. Dividends.
 - 2. Interest.
 - 3. Tax withheld.
 - 4. Royalties.
 - 5. Ordinary income.
 - 6. Real estate.
 - 7. Other rental.
 - 8. Other portfolio.

- d.* 1099-S.
 - 1. Real estate sales.

- e.* 1099-B.
 - 1. Aggregate profit and loss.
 - 2. Realized profit and loss.

- f.* 1098.
 - 1. Mortgage interest.

- g.* 1099-G.
 - 1. Tax withheld.
 - 2. Taxable grant.
 - 3. Unemployment compensation.
 - 4. Agricultural subsidies.

- h.* 1099-DIV.
 - 1. Dividends.
 - 2. Tax withheld.
 - 3. Capital gains.
 - 4. Cash liquid distribution.
 - 5. Noncash liquid distribution.
 - 6. Investment expense.
 - 7. Ordinary dividends.

- i. 1099-INT.
 - 1. Interest.
 - 2. Tax withheld.
 - 3. Savings bonds.
 - 4. Interest forfeiture.
 - 5. Tax-exempt interest.

This rule is intended to implement Iowa Code section 422.15.
[ARC 7761B, IAB 5/6/09, effective 6/10/09]

701—38.15(422) Relief from joint and several liability under Iowa Code section 422.21(7) for substantial understatement of tax attributable to nonrequesting spouse or former spouse. Married or formerly married taxpayers are generally jointly and severally liable for the total tax, penalty, and interest from a joint return or from a return where the spouses file separately on the combined return. However, pursuant to Iowa Code section 422.21(7), a person who is eligible for relief under the criteria established in Section 6015 of the Internal Revenue Code may be relieved of liability for an understatement of Iowa tax that is attributable to erroneous items of the nonrequesting spouse or former spouse. For state income tax purposes, the requirements set forth in this rule shall control to the extent that they conflict with Section 6015 of the Internal Revenue Code.

38.15(1) Filing status required for relief from joint and several liability. For state income tax purposes, a married or formerly married taxpayer may qualify for relief from joint and several liability under Iowa Code section 422.21(7) only if the taxpayer filed a joint return or filed separately on a combined return.

38.15(2) Scope of relief for Iowa income tax purposes. An understatement of the tax is the excess of the tax required to be shown over the tax actually shown on the return. An erroneous item is any item resulting in an understatement or deficiency in Iowa taxes to the extent that the item is omitted from, or improperly reported or characterized on, an Iowa tax return, including Iowa deductions and tax credits that would not be included on a federal return.

38.15(3) Requirement to provide IRS determination or other evidence of eligibility.

a. If the person seeking relief from joint and several liability under Iowa Code section 422.21(7) also applied for tax relief from the federal government under Section 6015 of the Internal Revenue Code and received a final determination letter or other document issued by the Internal Revenue Service in connection with relief requested under Section 6015 of the Internal Revenue Code, the person is required to provide the department with a copy of such letter or document within the time frame set forth in subrule 38.15(6). Failure to provide this required information, if it exists, will result in the denial of the request for relief from joint and several liability under Iowa Code section 422.21(7).

b. If the person seeking relief from joint and several liability under Iowa Code section 422.21(7) also applied for federal relief under Section 6015 of the Internal Revenue Code but did not receive a final determination letter or other document issued by the Internal Revenue Service in connection with the requested relief, the person must provide the department with other evidence to support the position that the taxpayer is eligible for relief under Iowa Code section 422.21(7).

c. If the person seeking relief under Iowa Code section 422.21(7) did not apply for federal relief under Section 6015 of the Internal Revenue Code, the person must submit a written statement to the department detailing the reason for not applying for relief under Section 6015 of the Internal Revenue Code as well as evidence to support the position that the taxpayer is eligible for relief under Iowa Code section 422.21(7).

38.15(4) Burden of proof; evaluation of criteria listed under Section 6015 of the Internal Revenue Code. The burden is on the person seeking relief from joint and several liability to show that the person is eligible for relief under Iowa Code section 422.21(7). In determining whether the person seeking relief from joint and several liability is eligible for relief under Iowa Code section 422.21(7), the department shall apply this rule and the relevant criteria set forth in Section 6015 of the Internal Revenue Code and the related federal regulations.

38.15(5) *Protesting a denied request for relief from joint and several liability.* If the department denies a claim for relief from joint and several liability under Iowa Code section 422.21(7), the person seeking relief may protest the department's determination under 701—Chapter 7. The department will evaluate the protest by applying the criteria set forth in this rule and Section 6015 of the Internal Revenue Code and the related regulations. In protest proceedings, the burden is on the person seeking relief from joint and several liability to show that the person meets the criteria for relief under this rule and Section 6015 of the Internal Revenue Code.

38.15(6) *Time period for requesting relief from joint and several liability.* For tax periods beginning on or after January 1, 2004, relief from joint and several liability must be requested within two years after the date of the notice of assessment. However, an applicant who fails to meet this deadline may be granted equitable relief if the applicant satisfies the criteria listed under Section 6015(f) of the Internal Revenue Code and, if applicable, Internal Revenue Service Notice 2011-70, which became effective July 25, 2011.

38.15(7) *Notice to nonrequesting spouse or former spouse.* On or before 60 days from the date the person seeking relief from joint and several liability files a request with the department, the department may notify the nonrequesting spouse or former spouse of the request for relief. The notice will advise the nonrequesting spouse or former spouse of the right to intervene by filing a notice of intervention with the department in accordance with subrules 38.15(8) and 38.15(9). The notice shall not include the current address or contact information of the spouse or former spouse requesting relief. The department will use the last-known address of the nonrequesting spouse when sending the notice.

38.15(8) *Intervention by nonrequesting spouse or former spouse.* If the nonrequesting spouse or former spouse desires to intervene, such individual shall file a notice of intervention with the department not later than 60 days after the date the notice of the request for relief from joint and several liability is sent by the department to the nonrequesting spouse or former spouse, unless the department directs otherwise.

38.15(9) *Contents of notice of intervention.*

a. A notice of intervention must be in the following format:

DEPARTMENT OF REVENUE

Name of Intervenor

**NOTICE OF
INTERVENTION**

Address of Intervenor

Docket No. _____

b. A notice of intervention must contain all of the following, where applicable and known to the intervenor:

(1) The name, address, telephone number, and identification number of the taxpayer (i.e., social security number (SSN), federal identification number (FEIN), or individual tax identification number (ITIN) of the person who is requesting intervention);

(2) The docket number of the proceeding initiated by the person seeking relief from joint and several liability under Iowa Code section 422.21(7);

(3) A copy of a determination letter or other document, if any, issued by the Internal Revenue Service showing that the person seeking relief from joint and several liability under Section 6015 of the Internal Revenue Code has been granted or denied relief for the relevant tax years;

(4) A clear and concise statement of the grounds for intervention, all relevant facts, and the reasons why the intervenor agrees or disagrees with the person seeking relief from joint and several liability as to that person's entitlement to such relief;

(5) A citation to any specific statutes, rules, policies, decisions, or orders which may be relevant in the department's determination of the applicability of relief from joint and several liability to the person seeking such relief;

(6) Any information known to the petitioner relating to the department's treatment of similar cases; and

(7) The signature of the intervenor at the conclusion of the notice of intervention attesting to the accuracy and truthfulness of the information set forth in the notice of intervention.

This rule is intended to implement Iowa Code section 422.21 as amended by 2020 Iowa Acts, House File 2641.

[ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 2393C, IAB 2/3/16, effective 3/9/16; ARC 5801C, IAB 7/28/21, effective 9/1/21]

701—38.16(422) Preparation of taxpayers' returns by department employees. A department employee can assist a taxpayer in the preparation and completion of the taxpayer's individual income tax returns and other state tax returns during the employee's hours of employment for the department in either of the following situations:

1. At the time the department employee is conducting an audit of the taxpayer.
2. When the department employee is requested to prepare a taxpayer's individual income tax return or other tax returns by the taxpayer, the taxpayer's spouse, or the taxpayer's authorized representative.

This rule is intended to implement Iowa Code section 421.17.

701—38.17(422) Resident determination. For Iowa individual income tax purposes, an individual is a "resident" if: (1) the individual maintains a permanent place of abode within the state, or (2) the individual is domiciled in the state. An individual who is determined to be a "resident" of Iowa is subject to Iowa income tax on all the individual's income for the taxable year, no matter whether the income is earned within Iowa or outside of Iowa, except when an item of income is specifically exempted from taxation by a provision of federal or Iowa law.

38.17(1) Permanent place of abode. The establishment of a permanent place of abode requires the maintenance of a place of abode over a sufficient period of time to create a well-settled physical connection with a given locality. Significant factors, among others, to be considered in determining whether an individual maintains such a permanent place of abode are: (1) the amount of time the individual spends in the locality; (2) the nature of the individual's place of abode; (3) the individual's activities in the locality; and (4) the individual's intentions with regard to the length and nature of the individual's stay.

There is a rebuttable presumption that an individual is maintaining a "permanent place of abode" if the individual maintains a place of abode within this state and spends more than 183 days of the tax year within this state. The term "place of abode" includes a house, apartment, condominium, mobile home, or other dwelling place maintained or occupied by the individual whether or not owned or rented by the individual. Situations where presence in the state for 183 days of the tax year may not cause an individual to be considered to be maintaining a "permanent place of abode" would include situations where presence in the state is not voluntary, such as confinement to a correctional facility or an extended hospital stay.

38.17(2) Domicile. An individual is "domiciled" in this state if the individual intends to permanently or indefinitely reside in Iowa and intends to return to Iowa whenever the individual may be absent from this state. Individuals who have moved into this state are domiciled in Iowa if the following three elements exist: (1) a definite abandonment of a former domicile; (2) actual removal to, and physical presence in this state; and (3) a bona fide intention to change domicile and to remain in this state permanently or indefinitely. *Julson v. Julson*, 255 Iowa 301, 122 N.W.2d 329, 331 (1963).

Every person has one and only one domicile. Domicile, for purposes of determining when an individual is "domiciled in this state," is largely a matter of intention which must be freely and voluntarily exercised. The intention to change one's domicile must be present and fixed and not dependent upon the happening of some future or contingent event. Because it is essentially a matter of

intent, precedents are of slight assistance and the determination of the place of domicile depends upon all the facts and circumstances in each case.

Once an individual is domiciled in Iowa, that status is retained until such time as the individual takes positive action to become domiciled in another state or country, relinquishes the rights and privileges of residency in Iowa, and meets the criteria set forth from *Julson v. Julson*, 255 Iowa 301, 122 N.W.2d, 329, 331 (1963). The director may require an individual claiming domicile outside the state of Iowa to provide documentation supporting establishment of another domicile. Absence from the state for 183 days of the tax year or for any other extended period of time does not alone show abandonment of an Iowa domicile.

a. There is a rebuttable presumption that an individual is domiciled in Iowa if the individual meets the following factors:

- (1) Maintains a residence or place of abode in Iowa, whether owned, rented, or occupied, even if the individual is in Iowa less than 183 days of the tax year, and either
- (2) Claims a homestead credit or military tax exemption on a home in Iowa, or
- (3) Is registered to vote in Iowa, or
- (4) Maintains an Iowa driver's license, or
- (5) Does not reside in an abode in any other state for more days of the tax year than the individual resides in Iowa.

b. There is a rebuttable presumption that an individual is not domiciled in Iowa if the individual meets all of the following factors:

- (1) Does not claim a homestead credit or military exemption on a home in Iowa,
- (2) Is not registered to vote in Iowa,
- (3) Does not maintain an Iowa driver's license,
- (4) Is in Iowa less than 183 days of the tax year; and
- (5) The individual maintains a place of abode outside of Iowa where the individual resides for at least 183 days of the tax year.

c. In addition to the factors listed for the above rebuttable presumptions for "permanent place of abode" or "domicile," some of the nonexclusive factors to consider in determining whether an individual is a resident of Iowa are as follows:

- (1) Maintains a place of abode in Iowa, whether owned, rented, or occupied.
- (2) Maintains an Iowa driver's license.
- (3) Maintains active membership in an Iowa church, club, or professional organization and participates as a result of such membership.
- (4) Documents, such as tax forms, legal documents, and correspondence, initiated during tax periods, use an Iowa address. Legal documents could include wills, deeds, or other contracts.
- (5) Immediate family members residing in Iowa who are claimed as dependents or rely, in whole or in part, on the taxpayer for their support.
- (6) Vehicles registered in Iowa.
- (7) Location of employment or active participation in a business within Iowa.
- (8) Active checking or savings accounts or use of safe deposit boxes located in Iowa.
- (9) Claims a benefit on the federal income tax return based upon an Iowa home being the principal place of residence. Examples include mortgage interest on principal residence and travel expenses while away from the principal place of residence.
- (10) Receives a number of services in Iowa from doctors, dentists, attorneys, CPAs or other professionals.

Unless shown to the contrary, married persons are presumed to have the same residence. Ordinarily, the residence of a minor is that of the person who has permanent custody over the minor.

An individual may qualify as a part-year resident of Iowa by: (1) not maintaining a permanent place of abode; and (2) not having a domicile in Iowa for the entire tax year. In determining part-year resident status, whether an individual is in or out of Iowa for 183 days may not be a factor.

38.17(3) *Resident determination for individuals on active duty military service.* The Soldiers and Sailors Civil Relief Act provides in 50 U.S.C. Appx § 574(1) that members of the armed forces of the

United States shall not be deemed to have lost a residence or domicile in any state, solely by being absent from that state in compliance with military or naval orders, or to have acquired a residence or domicile in another state while being absent from the state of residence. Thus, residents of Iowa who enter military service will retain their Iowa residence during the tenure of their military service or until they take positive action to change their state of residence.

For tax years beginning prior to January 1, 2011, residents of Iowa in military service will have Iowa income tax withheld from their military pay except when the military pay is earned in a combat zone and is totally or partially exempt from both federal and state income tax. An Iowa resident in military service can change state of residence for purposes of withholding of state income tax by completing Form DD2058 and designating a state other than Iowa as the individual's new state of residence. The military payroll officer of the service person will accept the DD2058 form and stop withholding Iowa income tax from the service person's military pay and start withholding the state income tax of the state of new residence of the service person (assuming the new state of residence has an income tax and assuming the new state of residence requires withholding of income tax from wage payments to its residents in military service). However, the completion of the DD2058 form by the "former Iowa resident" will not be considered as a valid change of residence for Iowa income tax purposes unless the service person was physically residing in the new state of residence at the time the DD2058 form was completed and the service person took other actions to show intent to change state of residence. Other actions to show intent to change state of residence would include: (1) registering to vote in the new state; (2) purchasing real property in the new state; (3) titling and registering vehicles in the new state; (4) notifying the state of previous residence of the state of residence change; (5) preparing a new last will and testament which indicates the new residence; and (6) complying with the tax laws of the state of new residence. For tax years beginning on or after January 1, 2011, see rule 701—40.76(422) regarding the exemption of active duty pay for both resident and nonresident members of the armed forces, armed forces military reserve, or the national guard.

Military personnel who are residents of other states and who come to Iowa as a result of military or naval orders, but who later decide to become legal or actual residents of Iowa, or military personnel who purchase residential property in Iowa and claim homestead credits or the military exemption for the property for property tax purposes are presumed to be residents of Iowa for income tax purposes.

Military personnel who are not residents of the state of Iowa and who receive military pay for service in Iowa shall not be considered to have received this income for services performed within Iowa or from sources within Iowa. These nonresidents of Iowa will be taxable on nonmilitary wages for personal services in Iowa they receive while stationed in Iowa. These individuals will also be taxable to Iowa on incomes they receive from businesses, trades, professions, or occupations operated in Iowa during the time they are stationed in Iowa as well as on nonmilitary incomes from any other sources within Iowa.

Since military nonresidents of Iowa cannot be taxed on their military pay while they are stationed in Iowa, the military pay cannot be considered for purposes of Iowa's taxation of nonresidents in accordance with the Servicemembers Civil Relief Act, Public Law 108-189. The military pay of the nonresident of Iowa must be excluded from the computation of the nonresident credit set forth in rule 701—42.5(422). This exclusion from the computation of the nonresident credit applies to military pay of nonresident servicemembers who are in an active duty status as defined under Title 10 of the United States Code.

For tax years beginning before January 1, 2009, spouses of military personnel who earn wages and other incomes from Iowa sources are taxed on these incomes similarly to other nonresidents of Iowa. Spouses of Iowa resident military personnel who were nonresidents of Iowa at the time of the marriages with the Iowa residents will not be considered to be residents of Iowa until they actually reside in Iowa with their husbands or wives. For tax years beginning on or after January 1, 2009, spouses who earn wages from Iowa sources are not subject to Iowa income tax on these wages if one spouse who is present in Iowa is a member of the armed forces, the other spouse is present in Iowa solely to be with the military spouse, and the spouse who is a member of the armed forces maintains a domicile in another state. This treatment for tax years beginning on or after January 1, 2009, is required by the Military Spouses Residency Relief Act, Public Law No. 111-97.

38.17(4) *Examples of resident determination.*

a. Fred and Mary were domiciled in Iowa when Fred retired in 1994. They have a house in Iowa and a condominium in Florida. Prior to 1994, Fred and Mary spent approximately four months in Florida and the remaining eight months in Iowa. Fred owned a small business when he retired and was retained as a consultant and remained a member of the board of directors after retirement. Fred and Mary have friends and family in both Iowa and Florida. They are also involved in the activities of the local country club as well as other civic and service organizations in both locations. When Fred retired, he and Mary decided to spend more time in Florida, especially during the winter months. They usually leave for Florida in late October and return to Iowa in early April. They have transferred their automobile registrations to Florida and they have acquired Florida driver's licenses. They have registered to vote in Florida and have voted in Florida elections. They visit doctors and dentists in both locations as the need arises. They maintain bank accounts in both locations and have mail sent to the location at which they are physically residing. Fred and Mary usually return to Iowa for the Thanksgiving and Christmas holidays and Fred returns once a month to attend board meetings. They do not claim a homestead credit or military tax exemption on their Iowa home, but they do use their Iowa address on most of their legal documents and on their federal tax return. They also travel and vacation during the winter months and oftentimes leave Florida to vacation.

Fred and Mary would be considered Iowa residents because they have retained a permanent abode in Iowa.

b. Susan takes an apartment in Des Moines when her employer assigns her to the region office of a large accounting firm for a temporary period. She spends more than 183 days in Iowa, but she returns to her apartment in Ohio once a month to visit her friends and to check her mail. She intends to return to Ohio when her assignment in Des Moines is terminated. She has retained her Ohio driver's license and she is registered to vote in Ohio.

Susan would not be considered to be an Iowa resident because she has not established a "permanent" place of abode in Iowa, even though she is present in Iowa for more than 183 days. Also, she has not had a definite abandonment of her former domicile. Susan would be taxed on her Iowa income as a nonresident. However, if Susan was assigned to Des Moines on a permanent basis, she may be considered an Iowa resident even though she retains her apartment in Ohio.

c. John is an over-the-road truck driver and his job takes him out of Iowa for approximately 240 days a year. He is married and his wife, Mary, lives in Marshalltown, Iowa. His two school-age children attend school in that community and Mary also has a part-time job as a nurse for the neighborhood clinic. John gets home for most weekends and for the holidays. He is registered to vote in Iowa and utilizes the Iowa homestead and military tax exemptions. He does not own any other real property except a lakeside cabin in Minnesota, where the family vacations during the summer.

John would be considered an Iowa resident even though he is not present in the state for more than 183 days because John intends to return to Iowa whenever he is absent and has not taken any steps to establish residency in any other state.

d. Wilber, who is a resident of Idaho, has a heart attack while vacationing in Iowa. He is hospitalized in the University Hospitals in Iowa City. While there, the doctors also discover that he has a rare blood disorder and Wilber is confined to the hospital for nearly nine months, during which time he receives treatment.

Wilber's presence in Iowa is for a medical emergency. When an individual suffers a medical emergency while present in this state for other purposes and cannot be realistically moved from the state or in situations where an individual is confined to an institution as a result of seeking treatment, the time spent in Iowa would not count toward the 183-day rule. Also, Wilber's hospital room would not be considered a permanent place of abode.

e. Chuck and Linda both worked for a major manufacturing company in Iowa and both of them decided to take advantage of an early retirement package offered by their employer. They do not have any children, but Chuck has a brother who lives in Davenport, Iowa, and Linda has a sister who lives in Phoenix, Arizona. After retirement, Chuck and Linda sell their house and purchase a motor home. They spend their time traveling the United States and Canada. They do not have a place of abode in any state as they live in their new vehicle. They do not spend more than 183 days in any state during the

year. They retained their Iowa driver's licenses and their motor home is registered in Iowa. They also have bank accounts in both Iowa and Arizona, and they have their mail sent to Chuck's brother as well as Linda's sister. They show Iowa as their state of residence for federal income tax purposes. They are not registered to vote in any state.

Chuck and Linda would be considered residents of Iowa. They have not shown an intention to change domicile and remain in another state permanently or indefinitely.

This rule is effective for tax years beginning on or after January 1, 1995.

This rule is intended to implement Iowa Code sections 422.3, 422.4 and 422.16.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9103B, IAB 9/22/10, effective 10/27/10; ARC 9822B, IAB 11/2/11, effective 12/7/11; ARC 1303C, IAB 2/5/14, effective 3/12/14]

701—38.18(422) Tax treatment of income repaid in current tax year which had been reported on prior Iowa individual income tax return. For tax years beginning on or after January 1, 1992, if a taxpayer repays in the current tax year an amount of income that had been reported on the taxpayer's Iowa individual income tax return for a prior year that had been filed with the department and the taxpayer would have been eligible for a tax benefit under similar circumstances under Section 1341 of the Internal Revenue Code, the taxpayer will be eligible for a tax benefit on the Iowa return for the current tax year. The tax benefit will be either the reduced tax on the Iowa return for the current tax year due to the deduction of the repaid income or the reduction in tax on the Iowa return or returns for the prior year(s) due to the exclusion of the repaid income. The reduction in tax from the return for the prior year may be claimed as a refundable credit on the return for the current tax year.

EXAMPLE A: A taxpayer reported \$7,000 in unemployment benefits on the taxpayer's 1994 Iowa return that the taxpayer had received in 1994. In early 1995 the taxpayer was notified that \$4,000 of the unemployment benefits had to be repaid. The benefits were repaid by the end of 1995. The taxpayer claimed a deduction on the 1995 Iowa return for the amount of unemployment benefits repaid during 1995 which had been reported on the taxpayer's 1994 Iowa return as that action gave the taxpayer a greater reduction in Iowa income tax liability than the taxpayer would have received from a reduction in tax on the 1994 return by recomputing the liability by excluding the repaid income.

EXAMPLE B: A taxpayer had received a \$5,000 bonus in 1994 which was reported on the taxpayer's 1994 Iowa return. In 1995 the taxpayer's employer advised the employee that the bonus was awarded in error and to be repaid. The \$5,000 bonus was repaid to the employer by the end of 1995. The taxpayer claimed a credit of \$440 on the 1995 Iowa return for repayment of the bonus in 1995. This represented the reduction in tax for 1994 from recomputing the tax liability for that year without the \$5,000 bonus. This provided the taxpayer a greater tax benefit than the taxpayer would have received from claiming a deduction on the 1995 Iowa return from repayment of the bonus.

This rule is intended to implement Iowa Code section 422.5 as amended by 1996 Iowa Acts, Senate File 2168.

701—38.19(422) Indication of dependent child health care coverage on tax return. Rescinded ARC 4118C, IAB 11/7/18, effective 12/12/18.

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 [Filed ARC 5801C (Notice ARC 5613C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]

[◇] Two or more ARCs

CHAPTER 230
EXEMPTIONS PRIMARILY BENEFITING MANUFACTURERS AND
OTHER PERSONS ENGAGED IN PROCESSING

Rules in this chapter include cross references to provisions in 701—Chapters 15, 18 and 26 that were applicable prior to July 1, 2004.

701—230.1 Reserved.

701—230.2(423) Carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services used in processing. An expanded definition of “processing” is allowed to manufacturers of food products for human consumption using carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services. For the purposes of this rule, the rental or leasing of tangible personal property is treated as the furnishing of a taxable service and not as the sale of tangible personal property.

230.2(1) Rescinded IAB 1/2/19, effective 2/6/19.

230.2(2) The following activities constitute processing when performed by a manufacturer to create food products for human consumption. Any carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, or other taxable services primarily used in the performance of these activities is exempt from tax.

a. Treatment of material that changes its form, context, or condition in order to produce a marketable food product for human consumption. “Special treatment” of the material to change its form, context, or condition is not necessary to lawfully claim the exemption. Examples of “treatment” which would not be “special” are the following: the washing, sorting and grading of fruits or vegetables; the washing, sorting, and grading of eggs; and the mixing or agitation of liquids. By way of contrast, sterilization would be “special treatment.”

b. Maintenance of the quality or integrity of the food product and the maintenance or the changing of temperature levels necessary to avoid spoilage or to hold the food in marketable condition. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or other taxable service used in freezers, heaters, coolers, refrigerators, or evaporators used in cooling or heating which holds the food product at a temperature necessary to maintain quality or integrity or to avoid spoilage of the food or to hold the food product in marketable condition is exempt from tax. It is not necessary that the taxable service be used to raise or lower the temperature of the food. Also, processing of food products for human consumption does not cease when the food product is in marketable form. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used to maintain or to change a temperature necessary to keep the product marketable is exempt from tax.

c. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or other taxable service primarily used in the maintenance of environmental conditions necessary for the safe or efficient use of machinery or material used to produce the food product is exempt from tax. For example, electricity used to air-condition a room in which meat is stored is exempt from tax if the purpose of the air conditioning is to maintain the meat in a condition in which it is easy to slice rather than for the comfort of the employees who work in the room.

d. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service primarily used in sanitation and quality control activities is exempt from tax. Nonexclusive examples exempt from tax include taxable services used in pH meters, microbiology counters and incubators used to test the purity or sanitary nature of a food product. For example, electricity used in egg-candling lights would be exempt from tax. Also, electricity, steam, or any taxable service used to power equipment which cleans and sterilizes food production equipment would be exempt from tax. Electricity used to power refrigerators used to store food samples for testing would be exempt from tax. Finally, electricity used to power “bug lights” or other insect-killing equipment used in areas where food products are manufactured or stored would be exempt from tax.

e. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used in the formation of packaging for marketable food products for human consumption is exempt from tax. For example, electricity used in plastic bottle-forming machines by a food manufacturer is exempt from

tax if the plastic bottles will be used to hold a marketable food product, such as milk. Any electricity, steam, or other taxable service used in the heating, compounding, liquefying and forming of plastic pellets into these plastic bottles is exempt.

f. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used in placement of the food product into shipping containers is exempt from tax. For example, electricity used by a food manufacturer to place food products into packing cases, pallets, crates, shipping cases, or other similar receptacles is exempt.

g. Any carbon dioxide in liquid, solid, or gaseous form, electricity, steam, or taxable service used to move material which will become a marketable food product or used to move the marketable food product itself until shipment from the building of manufacture is exempt from tax. This includes, but is not limited to, taxable services used in pumps, conveyors, forklifts, and freight elevators moving the material or food product and taxable services used in door openers which open doors for forklifts or other devices moving the material or product. Any loading dock which is attached to a building of manufacture is a part of that building. Any electricity, steam, or taxable service used to move any food products to a loading dock is exempt from tax. If a food product is carried outside its building of manufacture by any conveyor belt system, electricity used by any portion of the system located outside the building is taxable.

This rule is intended to implement Iowa Code section 423.3(49).
[ARC 4218C, IAB 1/2/19, effective 2/6/19; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.3(423) Services used in processing. Electricity, steam, or any taxable service is used in processing only if the service is used in any operation which subjects raw material to some special treatment which changes, by artificial or natural means, the form, context, or condition of the raw material and results in a change of the raw material into marketable tangible personal property intended to be sold ultimately at retail. The following are nonexclusive examples of what would and would not be considered electricity, steam, or taxable services used in processing:

230.3(1) The sales price from the sale of electricity or steam consumed as power or used in the actual processing of tangible personal property intended to be sold ultimately at retail would be exempt from tax. The sales price is to be distinguished from that of electricity or steam consumed for the purpose of lighting, ventilating, or heating manufacturing plants, warehouses, or offices. The latter sales price would be taxable.

230.3(2) The sales price from electricity used in the freezing of tangible personal property, ultimately to be sold at retail, to make the property marketable would be exempt from sales tax. See *Fischer Artificial Ice & Cold Storage Co. v. Iowa State Tax Commission*, 81 N.W.2d 437 (Iowa 1957).

230.3(3) Electricity used merely in the refrigeration or the holding of tangible personal property for the purpose of preventing spoilage or to preserve the property in its present state would not be “used in processing” and, therefore, its sales price would be subject to tax. See *Fischer Artificial Ice, supra*.

Measurement of taxable and nontaxable use of electricity and steam. The exemption provided in the case of electricity or steam applies only upon the sales price from the sale of electricity or steam when the energy is consumed as power or is used in the processing of food products or other tangible personal property intended to be sold ultimately at retail, as distinguished from electricity or steam which is consumed for taxable purposes. When practical, electricity or steam consumed as power or used directly in processing must be separately metered and separately billed by the supplier thereof to clearly distinguish energy so consumed from electricity or steam which is consumed for purposes or under conditions in which the exemption would not apply. If it is impractical to separately meter electricity or steam which is exempt from that electricity or steam upon which tax will apply, the purchaser must furnish an exemption certificate to the supplier with respect to what percentage of electricity or steam in the case of each purchaser is subject to the exemption. Reference 701—subrule 15.3(2). The exemption certificate must be supported by a study showing how the percentage was developed. When a certificate and study are accepted by the supplier as a basis for determining exemption, any changes in the processing method, changes in equipment or alterations in plant size or capacity affecting the percentage of exemption will necessitate the filing of a new and revised statement by the purchaser.

When the electric or steam energy is separately metered, enabling the supplier to accurately apply the exemption in the case of processing energy, the purchaser need only file an exemption certificate since the supplier, under such conditions, will separately record and compute the consumption of energy which is exempt from tax apart from that energy which is subject to tax.

This rule is intended to implement Iowa Code section 423.3(50).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.4(423) Chemicals, solvents, sorbents, or reagents used in processing. Chemicals, solvents, sorbents, and reagents directly used and consumed, dissipated, or depleted in processing tangible personal property intended to be sold ultimately at retail shall be exempt from sales and use tax. For the purpose of this processing exemption rule, free newspapers and shoppers' guides are considered to be retail sales. See 701—Chapter 211 for definition of the words "chemicals," "solvents," "sorbents," and "reagents."

For the purpose of this rule, a catalyst is considered to be a chemical, solvent, sorbent, or reagent. A catalyst is a substance which promotes or initiates a chemical reaction and, as such, is exempt from tax if consumed, dissipated, or depleted during processing of tangible personal property intended to be ultimately sold at retail.

To qualify for this exemption, all of the following conditions must be met:

1. The item must be a chemical, solvent, sorbent, or reagent.
2. The chemical, solvent, sorbent, or reagent must be directly used and consumed, dissipated, or depleted during processing as defined in referenced rule 701—18.29(422,423).
3. The processing must be performed on tangible personal property intended to be sold ultimately at retail.
4. The chemical, solvent, sorbent, or reagent need not become an integral or component part of the processed tangible personal property.

This rule is intended to implement Iowa Code section 423.3(51).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.5(423) Exempt sales of gases used in the manufacturing process. Sales of argon and other similar gases to be used in the manufacturing process are exempt from tax. For the purposes of this rule, only inert gases are gases that are similar to argon. An "inert gas" is any gas that is normally chemically inactive. It will not support combustion and cannot be used as either a fuel or as an oxidizer. Argon, helium, neon, krypton, radon, and xenon are inert gases. Oxygen, hydrogen, and methane are nonexclusive examples of gases that are not inert. These sales are exempt only if the gas is purchased by a "manufacturer," for use in "processing," as those terms are defined in subrules 230.15(3) and 230.15(4).

This rule is intended to implement Iowa Code section 423.3(52).
[ARC 2349C, IAB 1/6/16, effective 2/10/16; see Rescission note at end of chapter; ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.6(423) Sale of electricity to water companies. The sales price from the sale of electricity to water companies assessed for property tax pursuant to Iowa Code sections 428.24, 428.26, and 428.28, which is used solely for the purpose of pumping water from a river or well is exempt from sales tax. For the purposes of this rule, "river" means a natural body of water or waterway that is commonly known as a river. "Well," for the purposes of this rule, means an issue of water from the earth; a mineral spring; a pit or hole sunk into the earth to reach a water supply; a shaft or hole sunk to obtain oil, water, gas, etc.; or a shaft or excavation in the earth, in mining, from which run branches. *Pacific Gas and Electric Company v. Hufford*, 319 P.2d 1033, 1040 (Calif. 1957), citing Webster's New International Dictionary, 2nd ed., unabridged.

This rule is intended to implement Iowa Code section 423.3(53).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.7(423) Wind energy conversion property. The sales price from the sale of property used to convert wind energy to electrical energy or the sales price from the sale of materials used to manufacture, install, or construct property used to convert wind energy to electrical energy is exempt from tax.

For the purposes of this rule, “property used to convert wind energy to electrical energy” means any device which converts wind energy to usable electrical energy including, but not limited to, wind chargers, windmills, wind turbines, pad mount transformers, substations, power lines, and tower equipment.

This rule is intended to implement Iowa Code section 423.3(54).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.8(423) Exempt sales or rentals of core making and mold making equipment, and sand handling equipment. This rule is applicable to the period beginning on or after July 1, 2004.

230.8(1) Exempt sales and rentals of machinery and equipment. The sales price from sales or rentals of core making, mold making, and sand handling machinery and equipment directly and primarily used by a foundry in the mold making process is exempt from tax. For the purposes of this rule, a “foundry” is an establishment where metal, but not plastic, is melted and poured into molds. A nonexclusive list of equipment which may be exempt under this rule includes sand storage tanks, conveyers, patterns, mallor controllers, and sand mixers. A nonexclusive list of items which would not be exempted by this rule includes sand and other materials (as opposed to equipment) used to build molds or cores, and supplies. Services used in the mold making process are not exempted from tax by this rule. For the purposes of this rule, core making, mold making, and sand handling equipment also include replacement parts necessary for the operation of the equipment which is used directly and primarily by a foundry in the mold making process. See subrule 230.14(2) for definitions of “directly used,” “equipment,” and “machinery,” and see Iowa Code section 423.3(47) “d” for definitions of “replacement part” and “supplies.”

230.8(2) Exempt sales of fuel and electricity. The sales price from sales of fuel used in creating heat, power, or steam for, or used for generating electric current for, or electric current sold for use in machinery or equipment the sale or rental of which is exempt under subrule 230.8(1) is exempt from tax.

230.8(3) Exempt design and installation services. The sales price from furnishing design and installation services, including electrical and electronic installation, of machinery and equipment the sale or rental of which is exempt under subrule 230.8(1) is exempt from tax. Reference rule 701—26.16(422) for characterizations of the words “installation” and “electronic installation.”

This rule is intended to implement Iowa Code section 423.3(82).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.9(423) Chemical compounds used to treat water. Chemical compounds placed in water which is ultimately sold at retail should be purchased exempt from the tax. The chemical compounds become an integral part of property sold at retail. Chemical compounds placed in water which is directly used in processing are exempt from the tax, even if the water is consumed by the processor and not sold at retail.

Chemical compounds which are used to treat water that is not sold at retail or which are not used directly in processing shall be subject to tax. An example would be chlorine or other chemicals used to treat water for a swimming pool.

Special boiler compounds used by processors when live steam is injected into the mash or substance, whereby the steam liquefies and becomes an integral part of the product intended to be sold at retail and also becomes a part of the finished product, shall be exempt from tax.

This rule is intended to implement Iowa Code section 423.3(51).
[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.10(423) Exclusive web search portal business and its exemption. Effective on or after July 1, 2007, a business that qualifies as a web search portal business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the web search portal business. This exemption from sales and use tax also applies to the affiliates of a qualifying web search portal business.

230.10(1) Definitions. For the purpose of this exemption, the following definitions apply:

a. “Affiliate” means an entity that directly or indirectly controls, is controlled with or by, or is under common control with another entity.

b. "Control" means any of the following:

(1) In the case of a United States corporation, the ownership, directly or indirectly, of 50 percent or more of the voting power to elect directors.

(2) In the case of a foreign corporation, if the voting power to elect the directors is less than 50 percent, the maximum amount allowed by applicable law.

(3) In the case of an entity other than a corporation, 50 percent or more ownership interest in the entity, or the power to direct the management of the entity.

c. "Web search portal business" means an entity among whose primary businesses is to provide a search portal to organize information; to access, search, and navigate the internet, including research and development to support capabilities to organize information; and to provide internet access, navigation, and search functionalities.

230.10(2) Criteria to claim exemption. The following govern whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a web search portal business:

a. All of the following requirements must be met by a web search portal business for the purpose of this exemption:

(1) The business of the purchaser or lessee shall be as a provider of a web search portal.

(2) The web search portal business shall have a physical location in Iowa that is used for the operations and maintenance of the web search portal site on the internet, including but not limited to research and development to support capabilities to organize information and to provide internet access, navigation, and search.

(3) The web search portal business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the web search portal business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The web search portal business shall purchase, option, or lease Iowa land not later than December 31, 2008, for any initial investment. However, the December 31, 2008, date shall not affect the future purchases of adjacent land and additional investment in the initial or adjacent land to qualify as part of the minimum investment for purposes of this exemption.

b. Aggregation to meet requirements. A web search portal business that is seeking an exemption from sales and use tax under this exemption may meet the requirements found in subparagraphs 230.10(2)"a"(1) to (4) above, by aggregating various Iowa investments and other requirements with its business affiliates.

c. Failure to meet investment qualifications. If a web search portal business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the web search portal business, the web search portal business will lose the right to claim this exemption from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the web search portal business is required to pay all sales or use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

230.10(3) Exempt purchases. Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying web search portal business:

a. Computers and equipment that are necessary for the maintenance and operation of the web search portal business;

b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the web search portal;

c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph "b" above;

d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the web search portal;

e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the web search portal. This equipment includes, but is not limited to, exterior dedicated business-owned power substations, backup power generation systems, battery systems, and related infrastructure;

f. All equipment used in the racking system, including cabling and trays;

g. Fuel purchased by the web search portal business that is used in the backup power generation system and in all items listed in paragraphs “*a*” to “*f*.” This provision includes the fuel used in backup generators that may be located outside of the building that are used if power is interrupted to ensure the web search portal continues operation; and

h. Electricity purchased for use in operating the web search portal.

230.10(4) *Limitation of exemption.* The purchases or leases of the items listed in subrule 230.10(3) are only exempt if the items being purchased or leased are being used in the operation or maintenance of the web search portal business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose not related to operations or maintenance. Examples of items included in this limitation include but are not limited to:

a. Electricity not used for operation or maintenance, such as in the office or employee break room;

b. Tangible personal property used in areas of the web search portal facility that is not used for operation or maintenance, such as cleaning equipment and supplies;

c. Building materials that become part of real property, such as concrete, steel or roofing; and

d. Tangible personal property that becomes part of real property, such as a dishwasher.

230.10(5) *Initial date of exemption.* The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying web search portal business.

This rule is intended to implement Iowa Code section 423.3(92).

[ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.11(423) Web search portal business and its exemption. Effective on or after July 1, 2008, a business that qualifies as a web search portal business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the web search portal business. This exemption from sales and use tax also applies to the affiliates of a qualifying web search portal business.

230.11(1) *Definitions.* For the purpose of this exemption, the following definitions apply:

“*Affiliate*” means an entity that directly or indirectly controls, is controlled with or by, or is under common control with another entity.

“*Control*” means any of the following:

1. In the case of a United States corporation, the ownership, directly or indirectly, of 50 percent or more of the voting power to elect directors.

2. In the case of a foreign corporation, if the voting power to elect the directors is less than 50 percent, the maximum amount allowed by applicable law.

3. In the case of an entity other than a corporation, 50 percent or more ownership interest in the entity, or the power to direct the management of the entity.

“*Web search portal business*” means an entity whose business among other businesses is to provide a search portal to organize information; to access, search, and navigate the Internet, including research and development to support capabilities to organize information; or to provide Internet access, navigation, or search functionalities.

230.11(2) *Criteria to claim exemption.* The following governs whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a web search portal business:

a. Requirements. All of the following requirements must be met by a web search portal business for the purpose of this exemption:

(1) The business, among other businesses, of the purchaser or lessee shall be as a provider of a web search portal.

(2) The web search portal business shall have a physical location in Iowa that is used for the operations and maintenance of the web search portal site on the Internet, including but not limited to research and development to support capabilities to organize information and to provide Internet access, navigation, and search functionality.

(3) The web search portal business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the web search portal business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The web search portal business shall purchase, option, or lease Iowa land not later than December 31, 2008, for any initial investment. However, the December 31, 2008, date shall not affect the future purchases of adjacent land and additional investment in the initial or adjacent land to qualify as part of the minimum investment for purposes of this exemption.

b. Aggregation to meet requirements. A web search portal business that is seeking an exemption from sales and use tax under this exemption may meet the requirements found in subparagraphs 230.11(2)“a”(1) to (4) by aggregating various Iowa investments and other requirements with its business affiliates.

c. Failure to meet investment qualifications. If a web search portal business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the web search portal business, the web search portal business will lose the right to claim this exemption from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the web search portal business is required to pay all sales or use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

230.11(3) Exempt purchases. Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying web search portal business:

a. Computers and equipment that are necessary for the maintenance and operation of the web search portal business;

b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the web search portal business;

c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “b”;

d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the web search portal business;

e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the web search portal business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations; and back-up power generation systems, battery systems, and related infrastructure;

f. All equipment used in the racking system, including cabling and trays;

g. Fuel purchased by the web search portal business that is used in the back-up power generation system and in all items listed in paragraphs “a” to “f.” This includes the fuel used in the back-up generators that may be located outside the building and that are used if power is interrupted to ensure the web search portal business continues operation; and

h. Electricity purchased for use in operating the web search portal business.

230.11(4) Limitation of exemption. The purchase or lease of the items listed in subrule 230.11(3) is only exempt if the items being purchased or leased are being used in the operation or maintenance of the web search portal business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose. For example, the purchase of electricity for use in the office portion of the web search portal facility would not be exempt. The purchase of building materials that become real property would not be exempt. For example, the purchase of a dishwasher that will be

built into a kitchen area in the break room for employees would not be exempt from tax. The purchase of a dishwasher is the purchase of tangible personal property. However, upon installation, the dishwasher becomes part of the building and realty and is not exempt from Iowa sales or use tax.

230.11(5) *Initial date of exemption.* The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying web search portal business.

This rule is intended to implement Iowa Code section 423.3 as amended by 2008 Iowa Acts, House File 2233, section 1.

701—230.12(423) Large data center business exemption. Effective on or after July 1, 2009, a data center business that has a physical location in Iowa and that meets specific criteria may obtain an exemption from sales and use tax on specific purchases that are used in the operation and maintenance of the data center business.

230.12(1) *Definitions.* For the purpose of this rule, the following definitions apply:

“*Data center*” means a building rehabilitated or constructed to house a group of networked server computers in one physical location in order to centralize the storage, management, and dissemination of data and information pertaining to a particular business, taxonomy, or body of knowledge.

“*Data center business*” means an entity whose business, among other businesses, is to operate a data center.

230.12(2) *Criteria to claim exemption.* The following govern whether a business qualifies for an exemption from sales and use tax on purchases made or leases executed by a data center business:

a. Requirements. All of the following requirements must be met by a data center business for the purpose of this exemption:

(1) The business, among other businesses, of the purchaser or lessee shall be as a provider of a data center.

(2) The data center business shall have a physical location in Iowa that is, in the aggregate, at least 5,000 square feet in size used for the operation and maintenance of the data center.

1. A data center facility includes, but is not limited to, the centralization, storage, management and dissemination of data and information.

2. The physical location shall include the mechanical and electrical systems, redundant or backup power supplies, redundant data communications connections, environmental controls, and fire suppression systems for the data center business. The data center business’s physical location may also include a restricted access area employing advanced physical security measures such as video surveillance systems and card-based security or biometric security access systems.

(3) The data center business shall make a minimum investment in an Iowa physical location of \$200 million within the first six years of operation in Iowa beginning with the date the data center business initiates site preparation activities. The minimum investment includes the initial investment, including land and subsequent acquisition of additional adjacent land and subsequent investment at the Iowa location.

(4) The data center business shall comply with the applicable sustainable design and construction standards in Iowa Administrative Code 661—Chapter 310 as established by the state building code commissioner pursuant to Iowa Code section 103A.8B.

b. Failure to meet investment qualifications. If a data center business claiming exemption from sales and use tax under this exemption fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the data center business, the data center business will lose the right to claim this exemption from sales and use tax. Immediately following the loss of the right to claim this exemption from sales and use tax, the data center business is required to pay all sales and use taxes that would have been due on the purchase or rental of all purchases previously claimed exempt from sales and use tax, plus any and all applicable statutory penalty and interest due on the tax.

230.12(3) *Exempt purchases.* Sales and leases of the following are exempt from sales and use tax when sold or leased to a qualifying data center business:

- a. Computers and equipment that are necessary for the maintenance and operation of the data center business;
- b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the data center business;
- c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “b”;
- d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the data center business;
- e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the data center business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations and backup power generation systems, battery systems, and related infrastructure;
- f. All equipment used in the racking system, including cabling and trays;
- g. Fuel purchased by the data center business that is used in the backup power generation system and in all items listed in paragraphs “a” to “f.” This includes the fuel used in the backup generators that may be located outside the building and that are used if power is interrupted to ensure the data center business continues operation; and
- h. Electricity purchased for use in operating the data center business.

230.12(4) *Limitation of exemption.* The purchase or lease of the items listed in subrule 230.12(3) is only exempt if the items being purchased or leased are being used in the operation or maintenance of the data center business. Such purchases or leases will not be exempt from sales or use tax if the item is to be used in the business for another purpose. For example:

- a. The purchase of electricity for use in the office portion of the data center business facility would not be exempt.
- b. The purchase of building materials that become real property would not be exempt. For example, the purchase of a dishwasher that will be built into a kitchen area in the break room for employees would not be exempt from tax. Although the purchase of a dishwasher is the purchase of tangible personal property, upon installation, the dishwasher becomes part of the building and realty and, therefore, is not exempt from Iowa sales and use tax.

230.12(5) *Initial date of exemption.* The exemption from sales and use tax begins on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying data center business.

This rule is intended to implement Iowa Code section 423.3 as amended by 2009 Iowa Acts, Senate File 478, sections 197 through 202.

[ARC 8602B, IAB 3/10/10, effective 4/14/10]

701—230.13(423) Data center business sales and use tax refunds. Effective on or after July 1, 2009, data center businesses in Iowa meeting certain criteria may make an annual application to the department for a refund of 50 percent of the sales and use tax paid on the sales price of certain computers, equipment, fuel, and electricity used in the operation of the data center business.

230.13(1) *Definitions.* For the purpose of this rule, the following definitions apply:

“*Data center*” means a building rehabilitated or constructed to house a group of networked server computers in one physical location in order to centralize the storage, management, and dissemination of data and information pertaining to a particular business, taxonomy, or body of knowledge.

“*Data center business*” means an entity whose business, among other businesses, is to operate a data center.

“*Refund year*” means the year beginning with the date of initial site preparation of the data center facility.

“*Rehabilitation*” means a process of substantial repair, remodeling, or alteration, which may include but is not limited to upgrading mechanical systems, plumbing, roofing, wiring, windows, and heating and cooling systems, and performing significant interior or exterior structural modification. Although

they may be included as part of an overall rehabilitation project, singular actions such as the installation of a new information system or cosmetic changes to the interior or exterior appearance of a building do not, in and of themselves, constitute a rehabilitated building.

230.13(2) Basis and criteria for refunds. The amount, type, and length of refunds available to data center businesses depend upon the dollar amount of investment made, the type of construction undertaken, and the size in square feet of the facility.

a. Investment of \$136 million to \$200 million. Data center businesses which make investments in an Iowa facility of \$136 million to \$200 million in the first six years of operations and which facility contains at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first seven years of operation.

b. Investment of \$10 million to \$136 million—new construction. Data center businesses which make investments of \$10 million to \$136 million in the first six years of operations in the new construction of an Iowa facility that is at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first ten years of operation.

c. Investment of \$5 million to \$136 million—rehabilitation. Data center businesses which make investments of \$5 million to \$136 million in the first six years of operations in the rehabilitation of an Iowa facility that is at least 5,000 square feet are eligible for a refund of 50 percent of the sales and use tax paid on qualifying computers and equipment, backup fuel, and electricity for the first ten years of operation.

d. Investment of \$1 million to \$10 million—new construction. Data center businesses which make investments of \$1 million to \$10 million in the first three years of operations in the new construction of an Iowa facility of any size are eligible for a refund of 50 percent of the sales and use tax paid on fuel and electricity for the first five years of operation.

e. Investment of \$1 million to \$5 million—rehabilitation. Data center businesses which make investments of \$1 million to \$5 million in the first three years of operations in the rehabilitation of an Iowa facility of any size are eligible for a refund of 50 percent of the sales and use tax paid on fuel and electricity for the first five years of operation.

230.13(3) Purchases eligible for refunds. Sales and leases of the following are eligible for a refund of 50 percent of the sales and use tax paid when sold or leased to a qualifying data center business:

a. Computers and equipment that are necessary for the maintenance and operation of the data center business;

b. All equipment used for the operation and maintenance of the cooling system for the computers and equipment used in the operation of the data center business;

c. All equipment used for the operation and maintenance of the cooling towers for the cooling system referenced in paragraph “*b*”;

d. All equipment used for the operation and maintenance of the temperature control infrastructure for the computers and equipment used in the operation of the data center business;

e. All equipment used for the operation and maintenance of the power infrastructure that is used for the transformation, distribution, or management of electricity used for the operation and maintenance of the data center business. This equipment includes, but is not limited to, exterior dedicated business-owned power substations and backup power generation systems, battery systems, and related infrastructure;

f. All equipment used in the racking system, including cabling and trays;

g. Fuel purchased by the data center business that is used in the backup power generation system and in all items listed in paragraphs “*a*” to “*f*.” This includes the fuel used in the backup generators that may be located outside the building and that are used if power is interrupted to ensure the data center business continues operation; and

h. Electricity purchased for use in operating the data center business.

230.13(4) Sustainable design standards. In order to claim the refunds detailed in subrule 230.13(3), paragraphs “*a*” through “*h*,” data center businesses must comply with the sustainable design and

construction standards as required by Iowa Administrative Code 661—Chapter 310 as established by the state building code commissioner pursuant to Iowa Code section 103A.8B.

230.13(5) Failure to meet investment qualifications. If a data center business claiming a refund of sales and use tax under this rule fails to meet at least 80 percent of the minimum investment amount required within the first six years of operation beginning with the initiation of the site preparation activities by the data center business, the data center business will lose the right to claim the refund of sales and use tax. Immediately following the loss of the right to claim the refund of sales and use tax, the data center business is required to return the refund of sales and use tax paid on qualifying computers, equipment, fuel, and electricity, plus any and all applicable statutory penalty and interest due on the tax.

230.13(6) Limitation of refunds.

a. Use in operation or maintenance. The purchase or lease of the items listed in subrule 230.13(3) is only eligible for a refund of sales and use tax if the items being purchased or leased are being used in the operation or maintenance of the data center business. Such purchases or leases will not be eligible for a refund of sales and use tax if the item is to be used in the business for another purpose. For example:

(1) The purchase of electricity for use in the office portion of the data center business facility would not be eligible for a refund.

(2) The purchase of building materials that become real property would not be eligible for a refund. For example, the purchase of a dishwasher that will be built into a kitchen area in the break room for employees would not be eligible for a refund of tax. Although the purchase of a dishwasher is the purchase of tangible personal property, upon installation, the dishwasher becomes part of the building and realty and, therefore, is not eligible for a refund of Iowa sales and use tax.

b. State sales tax only. Refunds issued under this rule may not exceed 5 percent of the sales price of computers and equipment listed in subrule 230.13(3) and the fuel used to create heat, power and steam for processing or generating electrical current or from the sales price of electricity consumed by computers, machinery, or other equipment for operation of the data center business facility. The refund will not include any local option sales and services taxes.

c. Qualifying dates for fuel and electricity refund. To qualify for the 50 percent refund, the following must be on or after the first day of the first month through the last day of the last month of the refund year:

(1) The dates of the utility billing or meter reading cycle for the sale or furnishing of metered gas and electricity;

(2) The dates of the sale or furnishing of fuel for purposes of commercial energy; and

(3) The delivery of the fuel used for purposes of commercial energy.

230.13(7) Form and filing requirements.

a. Form. The owner of a data center business seeking a refund of sales and use tax imposed upon the sale or lease of any qualifying computers, equipment, fuel, and electricity must complete and file with the department Form IA 843, Claim for Refund. All of the information on the Claim for Refund must be completed.

b. Due date. The refund request form must be filed with the department no later than one year after the purchase of the qualifying computers, equipment, fuel, or electricity and within three months after the end of the refund year. The refund for sales and use tax begins with purchases made on and after July 1, 2009, or on and after the date of the initial investment in or the initiation of site preparation activities for the facility that will contain the qualifying data center business.

c. Date required. The refund request must include detailed schedules of the items being claimed including dates of purchase of tangible personal property, amount of purchase, and tax paid. The purchase of fuel and electricity must be computed and documented separately from other purchases.

d. Affidavit. In addition to completing and filing Form IA 843, Claim for Refund, the owner of a data center business seeking a refund as specified in this rule must also complete and file with the department an affidavit certifying that qualifications for the refund have been met. The affidavit must be filed prior to any refund request and must be approved by the department before a refund claim can be filed. The following format must be used for the affidavit:

Iowa Department of Revenue

Sales Tax Refund Affidavit

NAME OF AFFIANT	}	AFFIDAVIT FOR DATA CENTER BUSINESS
ADDRESS OF AFFIANT		

The undersigned duly swears that the named data center business complies with criteria to be entitled to refund of sales tax as required in Iowa Code section 423.4 as follows:

1. The facility is a data center business as defined by Iowa Code section 423.4(8) or 423.4(9);
2. The data center business facility will be a minimum of 5,000 square feet, as applicable, located upon Iowa land; and located at _____; with total square footage of _____;
3. The data center business will make an investment of (check only one):
 - \$136 million to \$200 million within the first six years of operation (refund available for first seven years).
 - \$10 million to \$136 million for new construction within the first six years of operation (refund available for first ten years).
 - \$5 million to \$136 million for rehabilitation of an existing facility within the first six years of operation (refund available for first ten years).
 - \$1 million to \$10 million for new construction within the first three years of operation (refund of tax paid on fuel and electricity only; refund available for first five years).
 - \$1 million to \$5 million for rehabilitation of an existing facility within the first three years of operation (refund of tax paid on fuel and electricity only; refund available for first five years).
4. The data center business facility will be constructed in accordance with the sustainable design and construction standards as required by Iowa Administrative Code 661—Chapter 310 and established by the building code commissioner pursuant to Iowa Code section 103A.8B;
5. Construction of the data center business facility was commenced on or after July 1, 2009; and the date of the initial site preparation or building rehabilitation was _____; and
6. Purchases of qualifying computers, equipment, fuel or electricity were made on or after July 1, 2009.

The undersigned duly swears that he or she is the owner of the qualifying data center business or that the undersigned is the authorized representative of the qualifying data center business and has the authority to sign this document. The undersigned swears that he or she has personal knowledge regarding the facts contained in this affidavit and that the statements set forth in this affidavit are true and accurate and that the qualifying data center business has met all of the requirements as contained herein.

_____ Name of Affiant	_____ Date
_____ Position of Affiant	

This rule is intended to implement Iowa Code section 423.4 as amended by 2009 Iowa Acts, Senate File 478, sections 198 through 202.
[ARC 8602B, IAB 3/10/10, effective 4/14/10]

701—230.14(423) Exemption for the sale of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies used for certain manufacturing purposes. Rules 701—230.14(423) to 701—230.20(423) exempt the sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies when used in an exempt manufacturing purpose. Rule

701—230.21(423) exempts the purchase of fuel used in such computers, computer peripherals, machinery, and equipment. Rule 701—230.22(423) exempts the service of designing or installing new industrial machinery and equipment.

230.14(1) *Generally.* The sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies is exempt from sales and use tax if the property is any of the following:

- a. Directly and primarily used in processing by a manufacturer (see rule 701—230.15(423)).
- b. Directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product (see rule 701—230.16(423)).
- c. Directly and primarily used in research and development of new products or processes of processing (see rule 701—230.17(423)).
- d. Computers or computer peripherals used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise (see rule 701—230.18(423)).
- e. Directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).
- f. Pollution-control equipment used by a manufacturer, including but not limited to that required or certified by an agency of this state or of the United States government (see rule 701—230.20(423)).
- g. Fuel used in creating heat, power, steam, or for generating electrical current, or from the sale of electricity, consumed by computers, computer peripherals, machinery, or equipment used in an exempt manner described in paragraph “a,” “b,” “c,” “e,” or “f” (see rule 701—230.21(423)).

230.14(2) *Computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies.*

a. *Computers and computer peripherals.* “Computer” and “computer peripheral” mean the same as defined in Iowa Code section 423.1.

b. *Machinery.* “Machinery” is any mechanical, electrical, or electronic device designed and used to perform some function and to produce a certain effect or result. The term includes not only the basic unit of the machinery, but also any adjunct or attachment necessary for the basic unit to accomplish its intended function. Machinery also includes all devices used or required to control, regulate, or operate a piece of machinery, provided such devices are directly connected with or are an integral part of the machinery and are used primarily for control, regulation, or operation of machinery. Other devices necessary to the operation of or used in conjunction with the operation of what would be ordinarily thought of as machinery are also considered to be machinery.

c. *Equipment.* In general usage, “equipment” refers to devices or tools used to produce a final product or achieve a given result. Exempt “equipment” under these rules includes tables on which property is assembled on an assembly line, if those tables are directly and primarily used in processing by a manufacturer.

d. *Replacement parts.* “Replacement part” means the same as defined in Iowa Code section 423.3(47)“d.”

e. *Supplies.* “Supplies” means the same as defined in Iowa Code section 423.3(47)“d.”

f. *Materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies.* “Materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies” means tangible personal property that is incorporated into a computer, computer peripheral, machinery, equipment, replacement part, or supply when the computer, computer peripheral, machinery, equipment, replacement part, or supply is constructed or assembled.

g. *Exclusions.* Sales of the following property, or materials used to construct or self-construct the following property, are not exempt under rules 701—230.14(423) to 701—230.20(423) regardless of how the property is used.

- (1) Land.
- (2) Intangible property.
- (3) Hand tools. “Hand tool” means a tool that can be held in the hand or hands and is powered by human effort.

(4) Point-of-sale equipment, computers, and computer peripherals. “Point-of-sale equipment, computers, and computer peripherals” means input, output, and processing equipment, computers, and computer peripherals used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and is located at the counter, desk, or other specific point where the transaction occurs. Point-of-sale equipment, computers, and computer peripherals do not include equipment, computers, and computer peripherals used primarily for depositing or withdrawing funds from financial institution accounts.

(5) Certain centrally assessed industrial machinery, equipment, computers, and computer peripherals. Property that is centrally assessed by the department of revenue under Iowa Code sections 428.24 to 428.29 or chapters 433, 434, 437, 437A, 437B, and 438 does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423). Property used but not owned by persons whose property is defined by such provisions of the Iowa Code, which would be assessed by the department of revenue if the persons owned the property, also does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423).

(6) Vehicles subject to registration. The general sales and use tax does not apply to vehicles subject to registration under Iowa Code chapter 321. Instead, such vehicles are subject to the fee for new registration under Iowa Code section 321.105A. Vehicles subject to registration are not exempt from the fee for new registration under rules 701—230.14(423) to 701—230.20(423), unless the vehicle is directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).

h. Examples. When used for an exempt purpose under rules 701—230.14(423) to 701—230.20(423), the following items may be exempt computers, computer peripherals, machinery, equipment, replacement parts, or supplies. This list is not all-inclusive.

- (1) Coolers, including coolers that do not change the nature of materials stored in them.
- (2) Equipment that eliminates bacteria.
- (3) Palletizers.
- (4) Storage bins.
- (5) Property used to transport raw, semifinished, or finished goods.
- (6) Vehicle-mounted cement mixers.
- (7) Self-constructed machinery and equipment.
- (8) Packaging and bagging equipment, including conveyer systems.
- (9) Equipment that maintains an environment necessary to preserve a product’s integrity.
- (10) Equipment that maintains a product’s integrity directly.
- (11) Quality control equipment.
- (12) Water used for cooling.

230.14(3) *Leased and rented property.* The exemptions under rules 701—230.14(423) to 701—230.22(423) apply to property regardless of how it is sold, including leased or rented property. The lease of computers, computer peripherals, machinery, equipment, replacement parts, or supplies may be exempt from sales and use tax if the lessee uses the property in an exempt manner under rules 701—230.14(423) to 701—230.20(423). Additionally, a lessor’s purchase of computers, computer peripherals, machinery, equipment, replacement parts, or supplies for lease or resale may be an exempt sale for resale under Iowa Code section 423.3(2).

230.14(4) *Record keeping.* Individuals claiming an exemption must always be able to prove they qualify for the exemption. To claim the exemptions described in this rule, purchasers must be able to prove that computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct the same are used for an exempt purpose under rules 701—230.14(423) to 701—230.20(423). When both exempt and nonexempt machinery and equipment are used in the same facility, replacement parts and supplies used in the machinery and equipment are exempt under these rules only to the extent the purchaser can prove which replacement parts

and supplies were used in the exempt machinery and equipment. Detailed, contemporaneous records should be maintained to verify that qualifying property is used for an exempt purpose. The precise records required may vary from purchaser to purchaser. Computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct the same are not exempt under rules 701—230.14(423) to 701—230.20(423) if the property is not used for an exempt purpose.

This rule is intended to implement Iowa Code section 423.3(47) as amended by 2020 Iowa Acts, House File 2641.

[ARC 2768C, IAB 10/12/16, effective 11/16/16; see Rescission note at end of chapter; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.15(423) Exemption for the sale of property directly and primarily used in processing by a manufacturer. The sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies is exempt from sales and use tax when the property is directly and primarily used in processing by a manufacturer.

230.15(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, computer peripherals, machinery, equipment, replacement parts, supplies, or materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, or supplies (see subrule 230.14(2));
- b. Directly used (see subrule 230.15(2));
- c. Primarily used (see subrule 230.15(2));
- d. Used in processing (see subrule 230.15(3)); and
- e. Used by a manufacturer (see subrule 230.15(4)).

230.15(2) Directly and primarily used.

a. *Directly used.*

(1) Generally. Property is “directly used” only if it is used to initiate, sustain, or terminate an exempt activity. In determining whether any property is “directly used,” consideration should be given to the following factors:

1. The physical proximity of the property to the exempt activity;
2. The temporal proximity of the use of the property to the use of other property that is directly used in the exempt activity; and
3. The active causal relationship between the use of the property and the exempt activity. The fact that a particular piece of property may be essential to the conduct of the activity because its use is required either by law or practical necessity does not, of itself, mean that the property is directly used.

(2) Examples. The following property typically is not directly used in an exempt manner:

1. Property used exclusively for the comfort of workers, such as air cooling, air conditioning, or ventilation systems.
2. Property used in support operations, such as a machine shop, where production machinery is assembled, maintained, or repaired.
3. Property used by administrative, accounting, or personnel departments.
4. Property used by security, fire prevention, first aid, or hospital stations.
5. Property used in communications or safety.

b. *Primarily used.* The primary use of property is the activity or activities for which the property is used more than half of the time.

230.15(3) Processing.

a. *Generally.* “Processing” and “receipt or producing of raw materials” mean the same as defined in Iowa Code section 423.3(47) “d.” With respect to raw materials produced from or upon real estate, “production of raw materials” is deemed to occur immediately following the severance of the raw materials from the real estate.

b. The beginning of processing. Processing begins with a processor's receipt or production of raw material. Thus, when a processor produces its own raw material, it is engaged in processing. Processing also begins when a supplier transfers possession of raw materials to a processor.

c. The completion of processing. Processing ends when the finished product is transferred from the processor or delivered for shipment by the processor. Therefore, a processor's packaging, storage, and transport of a finished product after the product is in the form in which it will be sold at retail are part of the processing of the product.

d. Examples of the beginning, intervening steps, and the ending of processing. Of the following, Examples A and B illustrate when processing begins under various circumstances; Example C demonstrates the middle stages of processing; and Example D demonstrates when the end of processing takes place.

EXAMPLE A: Company A manufactures fine furniture. Company A owns a grove of walnut trees that it uses as raw material. Company A's employees cut the trees, transport the logs to Company A's facility, store the logs in a warehouse to begin the curing process, and eventually take the logs to Company A's sawmill. The walnut trees are real property while they are growing. Thus, no "production of raw materials" has occurred with regard to the trees until they have been severed from the soil and transformed into logs. Processing of the logs begins when they are placed on vehicles for transport to Company A's factory. However, if the transport vehicles are "vehicles subject to registration," the vehicles are not exempt from the fee for new registration under this rule (see subparagraph 230.14(2) "g"(6)).

EXAMPLE B: Company A from the previous example also buys mahogany logs from a supplier in Honduras. Company A uses its equipment to offload the logs from railroad cars at its facility. Company A then stores and saws the logs as previously described in Example A. Processing begins when Company A offloads the logs from the railroad cars.

EXAMPLE C: Company C is a microbrewery. It uses a variety of kettles, vats, tanks, tubs, and other containers to mix, cook, ferment, settle, age, and store the beer it brews. Company C also uses a variety of pipes and pumps to move the beer among the various containers involved in the activity of brewing. All stages of this brewing are part of processing, including fermentation or aging (the transformation of the raw materials from one state to another) as well as the storage of hops in a bin and the storage of beer prior to bottling (the holding of materials in an existing state). Any movement of the product between containers is also a part of processing.

EXAMPLE D: After the brewing process is complete, Company C places its beer in various containers, stores the beer, and moves the beer to Company C's customers by a common carrier that picks up the beer at Company C's facility. Company C's activities of placing the beer into bottles, cans, and kegs, storing the beer after packaging, and moving the beer by use of a forklift to the common carrier's pickup site are part of processing.

230.15(4) Manufacturer.

a. Generally. Iowa Code section 423.3(47) "d"(4) abrogates *The Sherwin-Williams Company v. Iowa Department of Revenue*, 789 N.W.2d 417 (Iowa 2010).

b. Definitions.

"Construction contracting" means engaging in or performing a construction contract as defined in rule 701—219.8(423).

"Manufacturer" means the same as defined in Iowa Code section 423.3(47).

"Transporting for hire" means the service of moving persons or property for consideration, including but not limited to the use of a "personal transportation service" as that term is described in Iowa Code section 423.2(6) and rule 701—26.80(422,423).

c. Primarily engaged in an excluded activity. A person is not considered a manufacturer if the person is "primarily engaged" in any of the activities listed in Iowa Code section 423.3(47) "d"(4)(c). A person is "primarily engaged" in an activity if the person generates more than 50 percent of the person's gross revenue from its operating business from, or spends more than 50 percent of the person's time engaging in, any combination of those activities during the 12-month period after the date the person engages in one of the listed activities.

EXAMPLE 1: Company A makes widgets and repairs widgets damaged during use by its customers. Company A generates 70 percent of its revenue making widgets, and its employees spend 80 percent of their time making widgets. The remainder of its revenue and time are attributed to widget repair. Company A is not primarily engaged in “repairing tangible personal property or real property” (Iowa Code section 423.3(47) “d”(4)(c)(ii)) or any of the other enumerated activities from Iowa Code section 423.3(47) “d”(4)(c) because only 30 percent of its revenue and 20 percent of employee time are attributed to widget repair.

EXAMPLE 2A: Company B makes concrete and sells it for resale or directly to individual consumers without entering into a construction contract. Company B generates 100 percent of its revenue from such sales of concrete, and its employees spend 95 percent of their time making concrete during the 12-month period after it claims to be a manufacturer. Company B is not excluded from being considered a manufacturer because Company B’s production and sale of concrete are not part of construction contracting (Iowa Code section 423.3(47) “d”(4)(c)(i)).

EXAMPLE 2B: Company B begins construction contracting to sell its concrete. After 12 months of construction contracting (Iowa Code section 423.3(47) “d”(4)(c)(i)), Company B generates 55 percent of its revenue from construction contracting and 45 percent from resale sales or sales directly to consumers and spends 40 percent of its time performing construction contracts. Company B is no longer considered a manufacturer starting 12 months from the date it began construction contracting because it generates more than 50 percent of its gross revenue from construction contracting.

230.15(5) Manufacturing.

a. Activities commonly understood to be manufacturing. “Manufacturing” means the same as defined in Iowa Code section 423.3(47).

b. Premises primarily used to make retail sales.

(1) A person engaged in activities on a premises primarily used to make retail sales is not engaged in manufacturing at that premises and cannot claim this exemption for items used at that premises.

(2) The following are “premises primarily used to make retail sales”:

1. Restaurants.
2. Mobile food vendors, vehicles, trailers, and other facilities used for retail sales.
3. Retail bakeries.
4. Prepared food retailers establishments.
5. Bars and taverns.
6. Racing and gaming establishments.
7. Racetracks.
8. Casinos.
9. Gas stations.
10. Convenience stores.
11. Hardware and home improvement stores.
12. Grocery stores.
13. Paint or paint supply stores.
14. Floral shops.
15. Other retail stores.

c. Rebuttable presumption. In addition to the premises listed in paragraph 230.15(5) “b,” a premises shall be presumed to be “primarily used to make retail sales” when more than 50 percent of the gross sales of a business and its affiliates attributable to the premises are retail sales sourced to the premises under Iowa Code section 423.15(1) “a.”

(1) For purposes of paragraph 230.15(5) “c”:

“Attributable to the premises” means sales of tangible personal property at the premises or shipped from the premises to another location for sale or eventual sale.

“Premises” means any contiguous parcels, as defined in Iowa Code section 426C.1, which are owned, leased, rented, or occupied by a business or its affiliates and are operated by that business or its affiliates for a common business purpose. A “common business purpose” means the participation in any stage of manufacturing, production, or sale of a product. Whether a business is operating for a

common business purpose is a fact-based determination that will depend on the individual circumstances at issue.

(2) Calculation. If a business seeking to claim this exemption makes retail sales sourced to a premises under Iowa Code section 423.15(1)“a” and the location is not one of those listed in paragraph 230.15(5)“b,” the business shall determine whether a specific premises are primarily used to make retail sales by determining the amount of retail sales sourced to the premises under Iowa Code section 423.15(1)“a” during the 12-month period after the date the tangible personal property claimed to be exempt is used at the premises. The calculation should be done as follows:

$$\frac{\text{Retail sales sourced to the premises}}{\text{Gross sales attributable to the premises}}$$

If the result is less than or equal to 0.5 (or 50 percent), the premises is not primarily used to make retail sales. If the result is greater than 0.5, the premises is presumed to be primarily used to make retail sales.

(3) Rebutting the presumption. If a premises is presumed to be primarily used to make retail sales under subparagraph 230.15(5)“c”(2), a manufacturer may prove to the department the premises is not primarily used to make retail sales by providing information regarding the following nonexclusive list of factors to support its assertion:

1. The square footage of the premises allocated to the manufacturing process.
2. The number of employees or employee work hours allocated to the manufacturing process.
3. The wages and salaries of employees working at the premises allocated to the manufacturing process.
4. The cost of operating the premises attributable to the manufacturing process.

The department’s determination shall be a fact-based determination based on the information provided by a manufacturer and the individual circumstances at issue.

EXAMPLE 1: Company A owns a centralized facility where it makes widgets and distributes them to several of its own retail stores for retail sale. The retail stores are not contiguous to the centralized facility. Company A purchases a widget maker for its centralized facility and seeks to claim this exemption. Because the widgets sold are sold at the retail stores, the sales of those widgets are sourced to the retail stores where the sales occur. Therefore, none of the sales are retail sales sourced to the centralized facility. Because Company A does not make retail sales sourced to the centralized facility, the centralized facility is not primarily used to make retail sales.

EXAMPLE 2A: Company A makes widgets at its premises in Iowa, known as Location 1. Company A sells its widgets to retailers for resale and also makes some retail sales that are sourced to Location 1.

Twelve months ago, Company A purchased and put into use at Location 1 a new molding machine for making new widgets. Company A paid tax on the sales price of the molding machine at the time of purchase. During the 12-month period after Company A first used the molding machine, 2 percent of the gross sales attributable to Location 1 were from retail sales sourced to Location 1 and 98 percent of the gross sales attributable to Location 1 were from sales of widgets to retailers.

Because less than half of the sales attributable to Location 1 during the 12-month period after the molding machine was first used at Location 1 were generated from retail sales sourced to Location 1, Location 1 is not primarily used to make retail sales. Therefore, if Company A’s use of the molding machine satisfies all other requirements of the exemption, Company A’s activities occurring on the premises constitute manufacturing.

EXAMPLE 2B: Same facts as in Example 2A, except that Company A also owns a second, noncontiguous premises in Iowa, known as Location 2. At Location 2, Company A operates a factory that makes the same types of widgets as Location 1. Company A also makes substantial retail sales that are sourced to Location 2.

Twelve months ago, Company A purchased new molding machines for Location 1 and Location 2. Company A paid tax on the sales price of the molding machines. During this 12-month period, 2 percent

of the gross sales attributable to Location 1 were retail sales sourced to Location 1 and 98 percent of the gross sales attributable to Location 1 were from sales of widgets to distributors. Also during this 12-month period, 60 percent of the gross sales attributable to Location 2 were retail sales sourced to Location 2 and 40 percent of the gross sales attributable to Location 2 were from sales of widgets to distributors.

With respect to Location 1, the outcome is the same as in Example 1A. Because less than half of the sales attributable to Location 1 during the 12-month period after the molding machine was used at Location 1 were generated from retail sales sourced to Location 1, Location 1 is not primarily used to make retail sales.

However, Location 2 is presumed to be primarily used to make retail sales because more than half of the gross sales attributable to Location 2 are from retail sales sourced to Location 2.

EXAMPLE 2C: Same facts as in Example 2B. Company A decides to purchase new molding machines for both Location 1 and Location 2. Relying on the exemption determinations for the prior year, Company A pays sales tax on the purchase price of the molding machine for Location 2 but tenders an exemption certificate for the purchase of the molding machine for Location 1 and does not pay sales tax on that transaction.

Twelve months pass since the new molding machines were used at their respective locations. At Location 1, the gross sales attributable to the premises and retail sales sourced to the premises remained the same. However, at Location 2, Company A experienced a decrease in on-site retail sales and an increase in distribution sales. Because of a shift in sales, 45 percent of the gross sales attributable to Location 2 were retail sales sourced to Location 2, and 55 percent of the gross sales attributable to Location 2 were from sales of widgets to distributors.

Therefore, this year, Location 2 is no longer presumed to be primarily used to make retail sales because in the 12 months after the machine was used at Location 2, less than half of the gross sales attributable to Location 2 were from retail sales sourced to Location 2.

EXAMPLE 3A: Company A owns a premises on which it makes baseball bats. A portion of the premises is leased to Company B, which operates a retail store on the premises that sells clothing and is not commonly understood to be a manufacturer. Company A and Company B are unaffiliated entities.

Company A is seeking to purchase several new lathes to use in its bat production. In the last year, 95 percent of Company A's gross sales attributable to the premises came from selling bats to distributors, and 5 percent of Company A's gross sales attributable to the premises were from retail sales at a small on-site location. Also in the last year, 100 percent of Company B's gross sales attributable to the premises were from on-site retail sales.

Because Company A and Company B are not affiliated in any way, none of Company B's sales are attributable to Company A. Therefore, for purposes of Company A's determining its eligibility to claim the exemption, Company A's premises are not primarily used to make retail sales because less than half of its gross sales attributable to the premises are from retail sales sourced to the premises.

EXAMPLE 3B: Same facts as in Example 3A, except that Company B is an affiliate of Company A.

The result is the same; while Company B is an affiliate of Company A, the premises are not being operated for a common business purpose because Company B is not selling any of the bats manufactured by Company A. Therefore, none of Company B's business is attributable to Company A. For purposes of Company A's determining its eligibility to claim the exemption, Company A's premises are not primarily used to make retail sales because less than half of its gross sales attributable to the premises are from retail sales sourced to the premises.

EXAMPLE 3C: Same facts as in Example 3A, except that Company B is an affiliate of Company A and instead of operating a clothing store, Company B operates a sporting goods store where it sells some of the bats manufactured by Company A.

In this case, Company B's sales are attributable to Company A because both companies use the premises for a common business purpose: the sale of baseball bats manufactured by Company A. Therefore, the gross sales attributable to the premises of both Company A and Company B must be included in Company A's gross sales attributable to the premises. The premises will be presumed to be

primarily used to make retail sales if the combined retail sales by Company A and Company B that are sourced to the premises exceed 50 percent of the gross sales attributable to the premises.

EXAMPLE 4: Company A owns a premises not included in the list above at which it makes widgets. Company A sells 15 percent of its widgets by delivery to customers' homes, 30 percent to wholesalers, and the remaining 55 percent directly to customers who pick up widgets at the premises. Company A's premises is presumed to be primarily used to make retail sales.

Company A dedicates 75 percent of the square footage of the premises to the production of widgets, 20 percent to storage, and 5 percent to a loading dock. Company A employs a total of 50 people, 40 of whom work on the production floor making widgets. Company A's production staff accounts for 80 percent of its total wages and salaries paid to all employees. The cost of operating the widget production area accounts for 90 percent of Company A's total expenses. Upon claiming this exemption, Company A provides information satisfactory to the department to demonstrate these facts. Company A qualifies for the exemption.

230.15(6) *Replacement parts and supplies.*

a. Replacement parts. To qualify for exemption under this rule, replacement parts must satisfy the definition contained in Iowa Code section 423.3(47) "d." In addition to the other requirements, an exempt replacement part must replace a component of a computer, computer peripheral, machinery, or equipment that is directly and primarily used in processing by a manufacturer. Tangible personal property is not an exempt replacement part under this rule if the property exclusively replaces a component of a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in processing by a manufacturer.

b. Supplies. To qualify for exemption under this rule, supplies must satisfy the definition contained in Iowa Code section 423.3(47) "d." In addition to the other requirements, an exempt supply must be connected to, be used in conjunction with, or come into physical contact with a computer, computer peripheral, machinery, or equipment that is directly and primarily used in processing by a manufacturer, or an exempt supply must itself be directly and primarily used in processing by a manufacturer. Tangible personal property is not an exempt supply under this rule if the property exclusively is connected to, is used in conjunction with, or comes into physical contact with a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in processing by a manufacturer.

This rule is intended to implement Iowa Code section 423.3(47) "a"(1).

[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 4218C, IAB 1/2/19, effective 2/6/19; ARC 5099C, IAB 7/15/20, effective 8/19/20; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.16(423) Exemption for the sale of property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions. The sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies is exempt from sales and use tax when the property is directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product.

230.16(1) *Required elements.* To qualify for exemption under this rule, the purchaser must prove the property is:

a. Computers, computer peripherals, machinery, equipment, replacement parts, supplies, or materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, or supplies (see subrule 230.14(2));

b. Directly used (see subrule 230.15(2));

c. Primarily used (see subrule 230.15(2));

d. Used by a manufacturer (see subrule 230.15(4)); and

e. Used to maintain:

(1) A manufactured product's integrity;

- (2) Unique environmental conditions required for a manufactured product; or
- (3) Unique environmental conditions required for other computers, computer peripherals, machinery, equipment, replacement parts, or supplies directly and primarily used in processing by a manufacturer.

230.16(2) Replacement parts and supplies.

a. Replacement parts. To qualify for exemption under this rule, replacement parts must satisfy the definition contained in Iowa Code section 423.3(47)“d.” In addition to the other requirements, an exempt replacement part must replace a component of a computer, computer peripheral, machinery, or equipment that is directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer. Tangible personal property is not an exempt replacement part under this rule if the property exclusively replaces a component of a computer, computer peripheral, machinery, or equipment that is not directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer.

b. Supplies. To qualify for exemption under this rule, supplies must satisfy the definition contained in Iowa Code section 423.3(47)“d.” In addition to the other requirements, an exempt supply must be connected to, be used in conjunction with, or come into physical contact with a computer, computer peripheral, machinery, or equipment that is directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer, or an exempt supply must itself be directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer. Tangible personal property is not an exempt supply under this rule if the property exclusively is connected to, is used in conjunction with, or comes into physical contact with a computer, computer peripheral, machinery, or equipment that is not directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, computer peripherals, machinery, and equipment used in processing by a manufacturer.

230.16(3) Example of property directly and primarily used to maintain integrity or unique environmental conditions. A manufacturer purchases a cooling system or heating system that qualifies as machinery. The manufacturer uses the system to directly and primarily maintain the proper temperature of other machinery and equipment. The manufacturer uses such machinery and equipment directly and primarily in processing. The system is not used for the comfort of the workers. Because the system directly and primarily maintains the environmental conditions necessary for machinery and equipment directly and primarily used in processing, the system is exempt from sales and use tax under this rule.

This rule is intended to implement Iowa Code section 423.3(47)“a”(2).

[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.17(423) Exemption for the sale of property directly and primarily used in research and development of new products or processes of processing. The sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies is exempt from sales and use tax when the property is directly and primarily used in research and development of new products or processes of processing.

230.17(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

a. Computers, computer peripherals, machinery, equipment, replacement parts, supplies, or materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, or supplies (see subrule 230.14(2));

b. Directly used (see subrules 230.15(2) and 230.17(3));

c. Primarily used (see subrule 230.15(2)); and

d. Used in research and development (see subrule 230.17(2)) of:

- (1) New products; or
- (2) Processes of processing.

230.17(2) “Research and development” means experimental or laboratory activity that has as its ultimate goal the development of new products or processes of processing.

230.17(3) Property is used “directly” in research and development only if it is used in actual experimental or laboratory activity that qualifies as research and development under this rule.

230.17(4) Replacement parts and supplies.

a. Replacement parts. To qualify for exemption under this rule, replacement parts must satisfy the definition contained in Iowa Code section 423.3(47) “*d.*” In addition to the other requirements, an exempt replacement part must replace a component of a computer, computer peripheral, machinery, or equipment that is directly and primarily used in research and development of new products or processes of processing. Tangible personal property is not an exempt replacement part under this rule if the property exclusively replaces a component of a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in research and development of new products or processes of processing.

b. Supplies. To qualify for exemption under this rule, supplies must satisfy the definition contained in Iowa Code section 423.3(47) “*d.*” In addition to the other requirements, an exempt supply must be connected to, be used in conjunction with, or come into physical contact with a computer, computer peripheral, machinery, or equipment that is directly and primarily used in research and development of new products or processes of processing, or an exempt supply must itself be directly and primarily used in research and development of new products or processes of processing. Tangible personal property is not an exempt supply under this rule if the property exclusively is connected to, is used in conjunction with, or comes into physical contact with a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in research and development of new products or processes of processing.

230.17(5) Examples.

EXAMPLE A: Company A is a hybrid seed producer. Company A maintains a research and development laboratory for use in developing new varieties of corn seed. Company A purchases the following items for use in its research and development laboratory: a laboratory computer for processing data related to the genetic structure of various corn plants, an electron microscope for examining the structure of corn plant genes, a steam cleaner for cleaning rugs in the laboratory offices, and office furniture for use in the laboratory offices. The laboratory computer and the microscope are “directly” used in the research in which the laboratory is engaged; the steam cleaner and the office furniture are not directly used in research. Therefore, the sales prices of the laboratory computer and the microscope are exempt from sales and use tax. The sales prices of the steam cleaner and the office furniture are not exempt from tax under this rule.

EXAMPLE B: Company B is a manufacturer of agricultural equipment. Company B is researching and developing a new tractor. Company B purchases materials to produce a prototype of its new tractor. The prototype tractor will be tested in various settings, including a laboratory and actual agricultural production. The materials used to produce the prototype tractor are exempt supplies directly and primarily used in research and production of new products. The sales price for the materials is exempt regardless of whether Company B sells the prototype tractor after testing, or if it scraps the prototype tractor after testing.

This rule is intended to implement Iowa Code section 423.3(47) “*a*”(3).

[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.18(423) Exemption for the sale of computers and computer peripherals used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise. The sales price of computers and computer peripherals is exempt from sales and use tax when the computers and computer peripherals are used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise. The sales price of machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct

computers, computer peripherals, machinery, equipment, replacement parts, and supplies is not exempt under this rule.

230.18(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers or computer peripherals (see Iowa Code section 423.1);
- b. Used in processing or storage of data or information (see subrule 230.18(2)); and
- c. Used by:
 - (1) An insurance company (see subrule 230.18(3));
 - (2) A financial institution (see subrule 230.18(3)); or
 - (3) A commercial enterprise (see subrule 230.18(3)).

230.18(2) Processing or storage of data or information. All computers store and process information. However, only if the “final output” for a user or consumer is stored or processed data will the computer be eligible for exemption from tax under this rule.

230.18(3) Insurance company, financial institution, or commercial enterprise.

a. *Insurance company.* “Insurance company” means the same as defined in Iowa Code section 423.3(47) “d.” Excluded from the definition of “insurance company” are benevolent associations governed by Iowa Code chapter 512A, fraternal benefit societies governed by Iowa Code chapter 512B, and health maintenance organizations governed by Iowa Code chapter 514B. This list of exclusions is not intended to be exclusive.

b. *Financial institution.* “Financial institution” means the same as defined in Iowa Code section 527.2.

c. *Commercial enterprise.* “Commercial enterprise” means the same as defined in Iowa Code section 423.3(47) “d.”

230.18(4) Exempt property. To qualify for exemption under this rule, tangible personal property must satisfy the definition of “computers” or “computer peripherals” contained in Iowa Code section 423.1. Other property, including machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies, is not exempt under this rule, even if the property is used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.

230.18(5) Examples of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise. A health insurance company has four computers. Computer A is used to monitor the temperature within the insurance company’s building. Computer A transmits messages to the building’s heating and cooling systems, which tell the systems when to raise or lower the level of heating or air conditioning. Computer B is used to store patient records and to recall those records on demand. Computer C is used to tabulate statistics regarding the amount of premiums paid in and the amount of benefits paid out for various classes of insured. Computer D is used to train the insurance company’s employees to perform various additional tasks or to better perform work the employees can already do. Computer D uses various canned programs to accomplish this function. The final output of Computer A is neither stored nor processed information. Therefore, Computer A does not meet the definition of an exempt computer. The final output of Computer B is stored information. The final output of Computer C is processed information. The final output of Computer D is processed information consisting of the training exercises appearing on the computer monitor. The sales prices of Computers B, C, and D are exempt from sales and use tax as computers used in processing or storage of data or information by an insurance company.

This rule is intended to implement Iowa Code section 423.3(47) “a”(4).

[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.19(423) Exemption for the sale of property directly and primarily used in recycling or reprocessing of waste products. The sales price of computers, computer peripherals, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies is exempt from sales and use tax when the property is directly and primarily used in recycling or reprocessing of waste products.

230.19(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

a. Computers, computer peripherals, machinery, equipment, replacement parts, supplies, or materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, or supplies (see subrule 230.14(2));

b. Directly used (see subrule 230.15(2));

c. Primarily used (see subrule 230.15(2)); and

d. Used in:

(1) Recycling of waste products (see subrule 230.19(2)); or

(2) Reprocessing of waste products (see subrule 230.19(2)).

230.19(2) Recycling and reprocessing.

a. “Recycling” is any process by which waste or materials that would otherwise become waste are collected, separated, or processed and revised or returned for use in the form of raw materials or products. Recycling includes, but is not limited to, the composting of yard waste that has been previously separated from other waste. Recycling does not include any form of energy recovery.

b. “Reprocessing” is not a subcategory of processing. Reprocessing of waste products is an activity separate and independent from the processing of tangible personal property.

c. Recycling or reprocessing generally begins when the waste products are collected or separated. Recycling or reprocessing generally ends when waste products are in the form of raw material or another non-waste product. Activities that occur between these two points and are an integral part of recycling or processing qualify as recycling or reprocessing.

230.19(3) Replacement parts and supplies.

a. Replacement parts. To qualify for exemption under this rule, replacement parts must satisfy the definition contained in Iowa Code section 423.3(47) “*d.*” In addition to the other requirements, an exempt replacement part must replace a component of a computer, computer peripheral, machinery, or equipment that is directly and primarily used in recycling or reprocessing of waste products. Tangible personal property is not an exempt replacement part under this rule if the property exclusively replaces a component of a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in recycling or reprocessing of waste products.

b. Supplies. To qualify for exemption under this rule, supplies must satisfy the definition contained in Iowa Code section 423.3(47) “*d.*” In addition to the other requirements, an exempt supply must be connected to, be used in conjunction with, or come into physical contact with a computer, computer peripheral, machinery, or equipment that is directly and primarily used in recycling or reprocessing of waste products, or an exempt supply must itself be directly and primarily used in recycling or reprocessing of waste products. Tangible personal property is not an exempt supply under this rule if the property exclusively is connected to, is used in conjunction with, or comes into physical contact with a computer, computer peripheral, machinery, or equipment that is not directly and primarily used in recycling or reprocessing of waste products.

230.19(4) Examples.

a. Computers, computer peripherals, machinery, and equipment that may be exempt from sales and use tax under this rule include, but are not limited to, compactors, balers, crushers, grinders, cutters, and shears if directly and primarily used in recycling or reprocessing.

b. End loaders, forklifts, trucks, conveyor systems, and other moving devices directly and primarily used in the movement of waste products during recycling or reprocessing may be exempt from sales and use tax under this rule.

c. A bin or other container used to store waste products before collection for recycling or reprocessing is not directly and primarily used in recycling or reprocessing, and its sales price is not exempt from sales and use tax under this rule.

d. A vehicle used directly and primarily for collecting waste products for recycling or reprocessing could be a vehicle used for an exempt purpose under this rule, and such a vehicle could be exempt from the fee for new registration. Thus, a garbage truck could qualify for this exemption if the truck is directly

and primarily used in recycling; however, a garbage truck primarily used to haul garbage to a landfill does not qualify for exemption under this rule.

EXAMPLE A: Company A recycles household waste. Company A uses several machines in its facility to separate waste products into recyclable and nonrecyclable materials and to further separate the recyclable materials into paper, plastic, or glass. The sales prices of all separating machines are exempt from sales and use tax as machines directly and primarily used in recycling of waste products.

EXAMPLE B: Company B uses grinding machines to convert logs, stumps, pallets, crates, and other waste wood into wood chips. Company B then uses its trucks to deliver the wood chips to local purchasers. The sales prices of the grinding machines are exempt from sales and use tax as machines directly and primarily used in recycling or reprocessing of waste products. The trucks used to transport the wood chips are not used in recycling or reprocessing because the wood chips are in their final form when loaded onto the trucks.

This rule is intended to implement Iowa Code sections 321.105A(2) “c”(24) and 423.3(47) “a”(5).
[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.20(423) Exemption for the sale of pollution-control equipment used by a manufacturer. The sales price of pollution-control equipment, including but not limited to equipment required or certified by an agency of Iowa or of the United States government, is exempt from sales and use tax when the property is used by a manufacturer. Other equipment, and computers, computer peripherals, machinery, replacement parts, supplies, and materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, and supplies are not exempt from sales and use tax under this rule.

230.20(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Pollution-control equipment (see subrule 230.20(2)); and
- b. Used by a manufacturer (see subrule 230.15(4)).

230.20(2) “Pollution-control equipment” is any disposal system or apparatus used or placed in operation primarily for the purpose of reducing, controlling, or eliminating air or water pollution. Other property, including replacement parts and supplies, is not exempt under this rule. Pollution-control equipment does not include any apparatus used to eliminate noise pollution. Liquid, solid, and gaseous wastes are included within the meaning of the word “pollution.” Pollution-control equipment specifically includes, but is not limited to, any equipment the use of which is required or certified by an agency of this state or of the United States government. Wastewater treatment equipment, dust mitigation systems, and scrubbers used in smokestacks are examples of pollution-control equipment. However, pollution-control equipment does not include any equipment used only for worker safety, such as a gas mask.

EXAMPLE: A manufacturer constructs a wastewater treatment facility to treat wastewater from its manufacturing facility. The wastewater treatment facility diverts wastewater from the local water treatment plant. The facility then converts wastewater into a biogas, which the manufacturer uses as an energy source in its manufacturing facility. The sales price of the pollution-control equipment used in the wastewater treatment facility is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) “a”(6).
[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.21(423) Exemption for the sale of fuel or electricity used in exempt property. The sales price of fuel or electricity consumed by computers, computer peripherals, machinery, or equipment that is exempt from sales and use tax under rule 701—230.14(423), 701—230.15(423), 701—230.16(423), 701—230.17(423), 701—230.19(423), or 701—230.20(423) is also exempt from sales and use tax. The sales price of electricity or other fuel consumed by replacement parts, supplies, computers, or computer peripherals used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise remains subject to tax even if such property is exempt under rules 701—230.14(423) to 701—230.20(423).

EXAMPLE: A manufacturer operates a power plant. The manufacturer uses energy from the power plant to operate machinery and equipment used directly and primarily in processing at its manufacturing facility. The fuel consumed in the manufacturer's power plant is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) "b."
[ARC 2768C, IAB 10/12/16, effective 11/16/16; ARC 5798C, IAB 7/28/21, effective 9/1/21]

701—230.22(423) Exemption for the sale of services for designing or installing new industrial machinery or equipment. The sales price from the services of designing or installing new industrial machinery or equipment is exempt from sales and use tax. The enumerated services of electrical or electronic installation are included in this exemption.

230.22(1) Required elements. To qualify for the exemption, the purchaser must prove the service is:

- a. A design or installation service (see subrule 230.22(2));
- b. Of new (see subrule 230.22(3)); and
- c. Industrial machinery or equipment (see subrule 230.22(4)).

230.22(2) Design or installation services include electrical and electronic installation. "Design or installation" services do not include any repair service.

230.22(3) "New" means never having been used or consumed by anyone. The exemption does not apply to design or installation services on reconstructed, rebuilt, repaired, or previously owned machinery or equipment.

230.22(4) Industrial machinery or equipment.

a. *Generally.* "Industrial machinery or equipment" means machinery or equipment, as defined in subrule 230.14(2). The sale of industrial machinery or equipment must also qualify for exemption under any of the following:

(1) Property used directly and primarily in processing by a manufacturer (see rule 701—230.15(423)).

(2) Property used directly and primarily by a manufacturer to maintain the integrity of the manufacturer's product or to maintain unique environmental conditions for computers, computer peripherals, machinery, or equipment (see rule 701—230.16(423)).

(3) Property used directly and primarily in research and development of new products or processes of processing (see rule 701—230.17(423)).

(4) Property used directly and primarily in recycling or reprocessing of waste products (see rule 701—230.19(423)).

(5) Pollution-control equipment used by a manufacturer (see rule 701—230.20(423)).

b. *Exclusions.* The following property is not industrial machinery or equipment regardless of how the purchaser uses it:

(1) Computers or computer peripherals (see Iowa Code section 423.1).

(2) Replacement parts (see Iowa Code section 423.3(47) "d").

(3) Supplies (see Iowa Code section 423.3(47) "d").

(4) Materials used to construct or self-construct computers, computer peripherals, machinery, equipment, replacement parts, or supplies (see paragraph 230.14(2) "f").

230.22(5) Billing. The sales price for designing or installing new industrial machinery or equipment must be separately identified, charged separately, and reasonable in amount for the exemption to apply. The exemption applies to new industrial machinery or equipment regardless of how it is purchased, including leased or rented machinery or equipment.

EXAMPLE: Dealer sells and installs two new machines for Manufacturer. Manufacturer uses one machine on its production floor, where the machine is directly and primarily used in processing. Manufacturer uses the other machine in its machine shop, where the machine is not directly and primarily used in processing. Dealer gives an invoice to Manufacturer that separately itemizes the sales prices for each machine and each installation. The machine used on the production floor is new industrial machinery or equipment, and the sales prices of the machine and its installation are exempt

from sales and use tax. The machine used in the machine shop is not new industrial machinery or equipment, and the sales prices of the machine and its installation are taxable.

This rule is intended to implement Iowa Code section 423.3(48).

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[Rescinded paragraph editorially removed, IAC Supplement 7/29/20]³

[Filed ARC 5798C (Notice ARC 5659C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

¹ Amendments to 230.5 (ARC 2349C, Item 7) rescinded by 2016 Iowa Acts, House File 2433, section 6, on 3/21/16. Amendments removed and prior language restored IAC Supplement 4/27/16.

² 230.14 to 230.22 (ARC 2349C, Items 8 to 16) rescinded by 2016 Iowa Acts, House File 2433, section 7, on 3/21/16. Rules removed IAC Supplement 4/27/16.

³ Paragraph 230.14(2)“a” rescinded by 2020 Iowa Acts, House File 2641, section 97, effective July 1, 2020.

SECRETARY OF STATE[721]

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721—8.1(17A) Petition for rule making. Any person or agency may file a petition for rule making with the secretary of state at the Secretary of State’s Office, First Floor, State Capitol Building, Des Moines, Iowa 50319, or the Secretary of State’s Office, Lucas State Office Building, Des Moines, Iowa 50319. A petition is deemed filed when it is received in either office. The agency must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the agency an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

SECRETARY OF STATE	
Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	PETITION FOR RULE MAKING

The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation to the particular portion or portions of the rule proposed to be amended or repealed, together with a quotation of the relevant language.
2. A citation to any law deemed relevant to the agency’s authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner’s arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.
6. Any request by petitioner for a meeting provided for by rule 721—8.4(17A).

8.1(1) The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative (if one is involved), and a statement indicating the person to whom communications concerning the petition should be directed.

8.1(2) The agency may deny a petition because it does not substantially conform to the required form.

721—8.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The agency may request a brief from the petitioner or from any other person concerning the substance of the petition.

721—8.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to the Deputy Secretary of State, Lucas State Office Building, Des Moines, Iowa 50319.

721—8.4(17A) Agency consideration.

8.4(1) Within 30 days after the filing of a petition, the agency must submit the petition, any accompanying brief, and the disposition of the petition to the administrative rules coordinator and to the administrative rules review committee. Upon request by petitioner in the petition, the agency must schedule a brief and informal meeting between the petitioner and the agency, a member of the agency, or a member of the staff of the agency, to discuss the petition. The agency may request the petitioner to submit additional information or argument concerning the petition. The agency may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the agency by any person.

8.4(2) Within 90 days after the filing of the petition, or within any longer period agreed to by the petitioner, the agency must, in writing, deny the petition, and notify petitioner of its action and the specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed notified of the denial or grant of the petition on the date when the agency mails or delivers the required notification to petitioner.

8.4(3) Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the agency's rejection of the petition.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code section 17A.7.

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[Filed ARC 5811C (Notice ARC 5397C, IAB 1/27/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 10
WAIVER RULES

721—10.1(17A) Definition. For purposes of this chapter, a “waiver” means action by the agency which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

721—10.2(17A) Scope of chapter. This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the agency in situations where no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

721—10.3(17A) Applicability. The agency may only grant a waiver from a rule if the agency has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The agency may not waive requirements created or duties imposed by statute.

721—10.4(17A) Criteria for waiver. In response to a petition completed pursuant to rule 721—10.6(17A), the agency may in its sole discretion issue an order waiving in whole or in part the requirements of a rule if the agency finds, based on clear and convincing evidence, all of the following:

1. The application of the rule would impose an undue hardship on the person for whom the waiver is requested;
2. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;
3. The provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and
4. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

721—10.5(17A) Filing of petition. A petition for a waiver must be submitted in writing to the agency as follows:

10.5(1) License or authorization application. If the petition relates to a license or authorization application, the petition shall be made in accordance with the filing requirements for the license or authorization in question.

10.5(2) Contested cases. If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case.

10.5(3) Other. If the petition does not relate to a license application or a pending contested case, the petition shall be submitted in writing to the secretary of state’s office.

721—10.6(17A) Content of petition. A petition for waiver shall include the following information where applicable and known to the requester:

1. The name, address, and telephone number of the entity or person for whom a waiver is being requested and the case number of any related contested case.
2. A description and citation of the specific rule from which a waiver is requested.
3. The specific waiver requested, including the precise scope and duration.
4. All relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in rule 721—10.4(17A). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes will justify a waiver.

5. A history of any prior contacts between the agency and the petitioner relating to the regulated activity, license, or authorization affected by the proposed waiver, including a description of each affected license or authorization held by the requester, any notices of violation, contested case hearings, or investigative reports relating to the regulated activity or license within the last five years.

6. All information known to the requester regarding the agency's treatment of similar cases.

7. The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question or which might be affected by the granting of a waiver.

8. The name, address, and telephone number of any entity or person who would be adversely affected by the granting of a petition.

9. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Signed releases of information authorizing persons with knowledge regarding the request to furnish the agency with information relevant to the waiver.

721—10.7(17A) Additional information. Prior to issuing an order granting or denying a waiver, the agency may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the agency may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the secretary of state, or their designees, a committee of the agency, or a quorum of the agency.

721—10.8(17A) Notice. The agency shall acknowledge a petition upon receipt. The agency shall ensure that, within 30 days of the receipt of the petition, notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law. In addition, the agency may give notice to other persons. To accomplish this notice provision, the agency may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and provide a written statement to the agency attesting that notice has been provided.

721—10.9(17A) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case and shall otherwise apply to agency proceedings for a waiver only when the agency so provides by rule or order or is required to do so by statute.

721—10.10(17A) Ruling. An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

10.10(1) Agency discretion. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the agency, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the agency based on the unique, individual circumstances set out in the petition.

10.10(2) Burden of persuasion. The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the agency should exercise its discretion to grant a waiver from an agency rule.

10.10(3) Narrowly tailored exception. A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

10.10(4) Administrative deadlines. When the rule from which a waiver is sought establishes administrative deadlines, the agency shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

10.10(5) Conditions. The agency may place any condition on a waiver that the agency finds desirable to protect the public health, safety, and welfare.

10.10(6) Time period of waiver. A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic

right to renewal. At the sole discretion of the agency, a waiver may be renewed if the agency finds that grounds for a waiver continue to exist.

10.10(7) *Time for ruling.* The agency shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the agency shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

10.10(8) *When deemed denied.* Failure of the agency to grant or deny a petition within the required time period shall be deemed a denial of that petition by the agency. However, the agency shall remain responsible for issuing an order denying a waiver.

10.10(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

721—10.11(17A) Public availability. All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the agency is authorized or required to keep confidential. The agency may accordingly redact confidential information from petitions or orders prior to public inspection.

721—10.12(17A) Cancellation of a waiver. A waiver issued by the agency pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the agency issues an order finding any of the following:

1. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or
2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
3. The subject of the waiver order has failed to comply with all conditions contained in the order.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

721—10.13(17A) Violations. Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

721—10.14(17A) Defense. After the agency issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

721—10.15(17A) Judicial review. Judicial review of the agency's decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.

[ARC 5811C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code section 17A.9A.

[Filed emergency 2/2/01—published 2/21/01, effective 2/2/01]

[Filed 4/19/01, Notice 2/21/01—published 5/16/01, effective 6/20/01]

[Filed ARC 5811C (Notice ARC 5397C, IAB 1/27/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 10
ADMINISTRATIVE RULES

[Prior to 6/3/87, Transportation Department[820]—(01.B) Ch1]

761—10.1(17A) General.

10.1(1) Definitions. The definitions in Iowa Code section 17A.2 and the definition of “small business” in Iowa Code section 17A.4A are hereby adopted. In addition:

“*Commission*” means the Iowa transportation commission.

“*Department*” means the Iowa department of transportation.

“*Director*” means the director of transportation or the director’s designee.

10.1(2) Address. The mailing address of the department’s rules administrator is: Rules Administrator, Government and Community Relations, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. The email address of the rules administrator may be found on the department’s website at iowadot.gov/administrativerules.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 2889C, IAB 1/4/17, effective 2/8/17; ARC 4492C, IAB 6/5/19, effective 7/10/19; Editorial change: IAC Supplement 7/28/21]

761—10.2(17A) Rule making.

10.2(1) Notice of Intended Action—approval and content. Written authorization to publish proposed rules under Notice of Intended Action in the Iowa Administrative Bulletin shall be made by the director. Each commissioner shall be sent a copy of the Notice of Intended Action before its publication in the Iowa Administrative Bulletin. The Notice of Intended Action shall contain:

a. A copy of the complete text of the proposed rules and a brief explanation of the purpose of the proposed rules.

b. The specific legal authority for the proposed rules.

c. The methods that persons and agencies may use to present their views on the proposed rules. In addition to providing for the submission of written comments, the Notice shall afford any interested person or agency the opportunity to make an oral presentation.

d. Any other information required by statute or rule.

10.2(2) Notice of Intended Action—submission of written comments and written requests to make an oral presentation.

a. With regard to proposed rules published under Notice of Intended Action, the department shall accept and consider, from any person or agency, written comments and written requests to make an oral presentation when prepared and submitted in conformance with the following:

(1) Comments and requests shall clearly state the name, address and telephone number of the person or agency authoring the comment or request and the number and title of the proposed rule as given in the Notice of Intended Action.

(2) If an oral presentation is requested, the requester is encouraged to set forth the general subject of the presentation.

(3) Comments and requests shall be submitted to the office specified in the Notice of Intended Action. To be considered, they must be received by the office no later than the date specified in the Notice. The date shall be no less than 20 days after publication of the Notice.

b. The receipt and acceptance for consideration of written comments and written requests shall be promptly acknowledged by the department.

(1) Written comments received after the deadline may be accepted by the department although their consideration is not assured.

(2) Written requests to make an oral presentation received after the deadline shall not be accepted.

c. In addition to the formal procedures contained in this rule, the department may solicit viewpoints or advice concerning proposed rules through informal conferences or consultations as the department may deem desirable.

10.2(3) Adoption and filing of rules.

a. The director shall adopt proposed rules unless statutes specifically provide for commission adoption. The commission shall approve rules prior to their adoption by the director.

b. Upon adoption of proposed rules by the director or the commission, the director shall file them in accordance with Iowa Code section 17A.5.

10.2(4) Regulatory analysis. A request for issuance of a regulatory analysis shall be submitted to the department’s rules administrator at the address in subrule 10.1(2).

10.2(5) Concise statement. If requested in accordance with this subrule, the department shall issue a concise statement of the principal reasons for and against a rule that has been adopted, incorporating therein the reasons for overruling considerations urged against the rule.

a. The request shall:

- (1) Clearly state the name, address and telephone number of the person or agency authoring the request and the number and title of the rule which is the subject of the request.
- (2) Be submitted in writing to the department’s rules administrator.
- (3) Be delivered to the administrator or postmarked no later than the thirtieth calendar day following adoption of the subject rule.

b. A requested concise statement shall be issued either at the time of rule adoption or within 35 days after the department’s rules administrator receives the request.

10.2(6) Registration.

a. *Trade or occupational associations.* The state office of a trade or occupational association may register its name and address with the department to receive copies of Notices of Intended Action.

(1) The request must be in writing and indicate the subject matter and the number of copies of Notice of Intended Action it wishes to receive.

(2) The trade or occupational association shall reimburse the department for the actual costs incurred in providing copies to it.

b. *Small businesses.* A small business or an organization of small businesses may register its name and address with the department to receive notification of Notices of Intended Action and of rules adopted and filed without a Notice of Intended Action which may have an impact on small business.

(1) The request must be in writing and may indicate the subject matter of rules it is interested in. An organization requesting registration shall indicate how many small businesses it represents.

(2) At the discretion of the department, notification shall consist of either a copy of the rules or a summary of the subjects and issues involved.

c. *Submission and acknowledgment of requests.* Requests for registration under this subrule shall be submitted to the department’s rules administrator. The receipt of requests for registration shall be promptly acknowledged by the department. The acknowledgment shall either:

- (1) Inform the requester that it is registered, or
- (2) State that the request is incomplete and indicate the additional information required.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 4492C, IAB 6/5/19, effective 7/10/19]

761—10.3(17A) Petitions for rule making.

10.3(1) The department shall accept and consider, from any person or agency, petitions for rule making when submitted to the department’s rules administrator by mail or email and prepared in conformance with the following:

a. Format:

IOWA DEPARTMENT OF TRANSPORTATION
800 Lincoln Way, Ames, Iowa 50010

PETITION BY (insert petitioner’s name)
FOR THE (insert one: adoption,
amendment or repeal)
OF (insert current rule number, if
applicable, and brief description
of subject matter)



DOCKET NO. _____

PETITION FOR RULE MAKING

(In separate numbered paragraphs, the petition shall include the following.)

1. The petitioner's name, address and telephone number.
2. The nature of the petitioner's interest in the matter.
3. The text or the essential terms and conditions of a proposed new rule, or the rule number and text of a rule proposed for amendment or a repeal. In addition, proposed amendments shall be illustrated to portray the changes in wording requested: Deletions are to be indicated by strike-throughs, and additions by underscoring.
4. The reasons for seeking the requested action, including any facts, views, data or arguments relevant to the request. Copies of statutes, rules or other supporting documents referenced in the petition shall be submitted as appendices to the petition or made available to the department upon request.
- *5. If desired, a request to meet informally with the department to discuss the petition.

(Signature of petitioner)

b. A petition for amendment or repeal of a rule shall pertain to a rule currently in effect at the time the petition is received by the department.

c. Petitions should be typewritten, although petitions legibly hand-printed in ink shall be accepted.

10.3(2) The date of receipt of a petition is the day it reaches the department's rules administrator. The administrator shall promptly notify the petitioner of the date of receipt and the assigned docket number.

10.3(3) If requested in the petition, the department shall schedule an informal meeting with the petitioner to discuss the petition.

10.3(4) The department shall notify the petitioner of the director's or commission's determination to grant or deny the petition. If the petition is denied, the notification shall include the reasons for denial.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 4492C, IAB 6/5/19, effective 7/10/19]

These rules are intended to implement Iowa Code sections 17A.1 to 17A.9, 17A.19, 307.12 and 307A.2.

[Filed 5/22/75]

[Filed 4/7/78, Notice 2/22/78—published 6/7/78, effective 6/7/78]

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[Filed without Notice 12/17/80—published 1/7/81, effective 2/11/81]

[Filed 3/8/85, Notice 1/16/85—published 3/27/85, effective 5/1/85]

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[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 7/5/90, Notice 4/4/90—published 7/25/90, effective 8/29/90]¹

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[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]

[Filed ARC 2231C (Notice ARC 2117C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]

[Filed ARC 2889C (Notice ARC 2779C, IAB 10/26/16), IAB 1/4/17, effective 2/8/17]

[Filed ARC 4492C (Notice ARC 4325C, IAB 3/13/19), IAB 6/5/19, effective 7/10/19]

[Editorial change: IAC Supplement 7/28/21]

¹ Effective date of amendments to 761—10.2(17A) and 10.3(17A) delayed until adjournment of the 1991 General Assembly by the Administrative Rules Review Committee at its meeting held August 15, 1990.

CHAPTER 11
WAIVER OF RULES

761—11.1(17A) Purpose and scope.

11.1(1) The purpose of this chapter is to establish a general process for granting waivers from the requirements of department rules. A waiver is an agency action which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

11.1(2) This chapter does not preclude the granting of waivers using another process if a statute or another department rule so provides. If the rule for which a waiver is sought has a specific waiver process of its own, this chapter is applicable only when it is specifically cited.

11.1(3) This chapter does not apply to contested case proceedings.

11.1(4) This chapter does not apply to rules that merely define the meaning of a statute or other provision of law if the department does not possess the delegated authority to bind the courts to any extent with its definition.

[ARC 5301C, IAB 12/2/20, effective 1/6/21]

761—11.2(17A) Authority to grant waiver. The director of transportation may, in response to a written petition submitted in accordance with rule 761—11.5(17A), grant a waiver from the requirements of a rule. The decision to grant a waiver shall be made at the sole discretion of the director and is final agency action.

761—11.3(17A) Criteria, considerations and limitations.

11.3(1) The director shall not grant a waiver from the requirements of a rule unless the director or the department has jurisdiction over the rule and the waiver is consistent with any applicable statute, constitutional provision, or other provision of law. The director shall not waive any requirement created or duty imposed by statute.

11.3(2) The director may grant a waiver from the requirements of a rule if the director finds, based on clear and convincing evidence, all of the following:

- a. Application of the rule will pose an undue hardship.
- b. The waiver will not prejudice the substantial legal rights of any person.
- c. The provisions of the rule subject to waiver are not specifically mandated by statute or another provision of law, and the waiver will not cause a denial of federal funds.
- d. Substantially equal protection of the public health, safety, and welfare will be afforded by means other than that prescribed in the rule.

11.3(3) The department shall evaluate each petition for a waiver based on the unique, individual circumstances set out in the petition. The burden of persuasion rests with the petitioner.

11.3(4) A waiver, if granted, shall provide the narrowest exception possible to the provisions of the rule.

11.3(5) The director may place any condition on a waiver that the director finds desirable to protect the public health, safety, and welfare.

11.3(6) A waiver shall not be permanent, unless the director finds that a temporary waiver would be impracticable.

11.3(7) If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the director, a waiver may be renewed if the director finds all of the factors set out in subrule 11.3(2) remain valid.

761—11.4(17A) Decision on waiver.

11.4(1) The director's decision to grant or deny a waiver in response to a written petition shall be in writing and contain:

- a. The name of the person to whom the decision pertains.
- b. A citation to the rule or portion thereof to which the decision pertains and a brief summary of the rule's requirements that are pertinent to the requested waiver.

c. The relevant facts and reasons upon which the decision is based. If a waiver is granted, the decision must include the findings set out in subrule 11.3(2).

d. The scope and duration of a waiver if one is granted.

e. Any other conditions placed on a waiver if one is granted.

11.4(2) Reserved.

761—11.5(17A) Petition for waiver.

11.5(1) *Petitioner.* Any person may petition the department for a waiver from the requirements of a rule. The petitioner must have a real and direct interest in the matter.

11.5(2) *Form of petition.* A petition for a waiver from the requirements of a rule must be in writing and state clearly at the top of the petition that it is a “petition for waiver of a rule.” The petition shall contain the following information where applicable and known to the petitioner:

a. The name, address and telephone number of the petitioner, and any license, permit or case number applicable to the requested waiver.

b. A description of and citation to the specific rule from which a waiver is requested.

c. The specific waiver requested, including its scope and duration.

d. The relevant facts and reasons the petitioner believes would justify the requested waiver. The petitioner should address each of the following:

(1) Why applying the rule will result in an undue hardship to the petitioner.

(2) Why waiving the rule will not prejudice the substantial legal rights of any other person.

(3) Whether the provisions of the rule are specifically mandated by statute or another law other than the rule.

(4) How substantially equal protection of the public health, safety, and welfare will be afforded by means other than those prescribed by the rule.

e. A history of any prior contacts between the petitioner and the department that are related to the requested waiver.

f. Whether the petitioner is currently a party to a rule making, declaratory order, contested case, judicial proceeding, or any other proceeding related to the requested waiver.

g. Information regarding the department’s treatment of similar situations.

h. The name, address and telephone number of any public agency or political subdivision that also regulates the activity in question or that may be affected if the waiver were granted.

i. The name, address and telephone number of any person or entity that may be adversely affected if the waiver were granted.

j. The name, address and telephone number of any person who has knowledge of facts relevant to the requested waiver.

k. Releases authorizing persons with knowledge of relevant facts to furnish that information to the department.

l. The signature of the petitioner and the date signed.

11.5(3) *Submission of petition.* A petition for waiver from the requirements of a rule shall be submitted to the rules administrator either by mail to Rules Administrator, Government and Community Relations, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or by email to the rules administrator’s email address listed on the department’s website at iowadot.gov/administrativerules.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 2889C, IAB 1/4/17, effective 2/8/17; ARC 4492C, IAB 6/5/19, effective 7/10/19; Editorial change: IAC Supplement 7/28/21]

761—11.6(17A) Action on petition. Following is the procedure for responding to a petition for a waiver from the requirements of a rule:

11.6(1) The department shall acknowledge receipt of a petition immediately.

11.6(2) Before a waiver is granted or denied, the department may request a petitioner to furnish additional information related to the petition.

11.6(3) The director shall issue a written decision to grant or deny a waiver within 120 days after the department receives the petition unless the petitioner agrees to a later time. However, if the matter is

also the subject of a contested case proceeding, the decision to grant or deny a waiver need not be issued until after the final decision in the contested case is issued.

11.6(4) The decision to grant or deny a waiver shall contain the information set out in rule 761—11.4(17A).

11.6(5) Within seven days after the decision is issued, the department shall transmit it to the petitioner.

11.6(6) Failure to grant or deny a waiver within the required time is deemed a denial.

11.6(7) The director's decision on a petition for a waiver from the requirements of a rule is final agency action.

11.6(8) A petition for a waiver from the requirements of a rule is independent of a contested case proceeding. Submission of a petition does not delay the time to request a contested case hearing, to appeal a proposed decision in a contested case, or to file a petition for judicial review of a final decision in a contested case.

11.6(9) A petition for a waiver from the requirements of a rule is not required to exhaust administrative remedies before judicial review of a department action under Iowa Code section 17A.19.

761—11.7(17A) Modification or cancellation of waiver. The department may, after notice and opportunity for hearing, modify or cancel a waiver granted pursuant to this chapter if the director finds any of the following:

1. A material fact upon which the waiver is based is not true or has changed.
2. The petitioner withheld or knowingly misrepresented a material fact relevant to the propriety or desirability of the waiver.
3. The petitioner has failed to comply with the conditions set forth in the decision granting the waiver.
4. The alternate means for ensuring that the public health, safety and welfare will be adequately protected after the waiver is granted are insufficient.

761—11.8(17A) Records.

11.8(1) All records relating to waivers granted or denied under this chapter are open records. However, if a record contains personal information that is confidential, only the portion of the record that is nonconfidential will be made available for public inspection.

11.8(2) The department's rules administrator shall, at a minimum, retain for five years records relating to waivers granted or denied under this chapter.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 2889C, IAB 1/4/17, effective 2/8/17; ARC 4492C, IAB 6/5/19, effective 7/10/19]

These rules are intended to implement Iowa Code section 17A.9A and Executive Order Number 11, dated September 14, 1999.

[Filed 3/7/01, Notice 1/10/01—published 4/4/01, effective 5/9/01]

[Filed 9/14/05, Notice 8/3/05—published 10/12/05, effective 11/16/05]

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[Filed ARC 2231C (Notice ARC 2117C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]

[Filed ARC 2889C (Notice ARC 2779C, IAB 10/26/16), IAB 1/4/17, effective 2/8/17]

[Filed ARC 4492C (Notice ARC 4325C, IAB 3/13/19), IAB 6/5/19, effective 7/10/19]

[Filed ARC 5301C (Notice ARC 5180C, IAB 9/23/20), IAB 12/2/20, effective 1/6/21]

[Editorial change: IAC Supplement 7/28/21]

CHAPTER 12
DECLARATORY ORDERS
[Prior to 11/8/06, see rule 761—10.4(17A)]

761—12.1(17A) Definitions.

“*Declaratory order*” means the department’s interpretation of a statute, rule or order as applied to specified circumstances. A declaratory order is issued in response to a petition for declaratory order.

“*Director*” means the director of transportation or the director’s designee.

“*Petition for declaratory order*” means a formal request from a person or agency to the department asking how the department will apply a statute, rule or order based on a specific set of facts contained in the petition. The purpose of the petition is to seek binding advice from the department, not to challenge a decision that the department has already made.

761—12.2(17A) Petition for declaratory order.

12.2(1) Any person or agency may file with the department a petition for declaratory order. The subject matter of the petition must be within the primary jurisdiction of the department.

12.2(2) The petition must be submitted to the rules administrator either by mail to Rules Administrator, Government and Community Relations, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or by email to the rules administrator’s email address listed on the department’s website at iowadot.gov/administrativerules.

12.2(3) The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

IOWA DEPARTMENT OF TRANSPORTATION
800 Lincoln Way, Ames, Iowa 50010

PETITION BY (insert petitioner’s name) FOR DECLARATORY ORDER ON (insert number of statute, rule, etc. and brief description of subject matter)	}	DOCKET NO. _____ PETITION FOR DECLARATORY ORDER
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(In separate numbered paragraphs, the petition shall include the following.)

1. The petitioner’s name, address and telephone number.
2. The exact words, passages, sentences or paragraphs of statutes, rules, etc. which are the subject of the inquiry.
3. A clear, concise and complete statement of all relevant facts for which the order is requested.
4. The uncertainties or conflicting interpretations which arise when the cited statutes, rules, etc. are applied to the facts.
5. (Optional) The interpretation urged based upon the facts set forth.
6. The reasons for the petition and a full disclosure of the petitioner’s interest.
7. Whether the petitioner is currently a party to a rule-making, contested case or judicial proceeding involving the controversy or uncertainty.
8. The names and addresses, when known, of other persons who may be affected by the declaratory order.

12.2(4) The petition must be dated and signed by the petitioner or, if applicable, petitioner’s representative.

12.2(5) If applicable, the petition must also include the name, address, and telephone number of the petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

12.2(6) The date of receipt of the petition is the day it reaches the department's rules administrator. The administrator shall promptly send an acknowledgment of receipt to the petitioner or, if applicable, petitioner's representative.

[ARC 2231C, IAB 11/11/15, effective 12/16/15; ARC 2889C, IAB 1/4/17, effective 2/8/17; ARC 4492C, IAB 6/5/19, effective 7/10/19; Editorial change: IAC Supplement 7/28/21]

761—12.3(17A) Notice of petition. Within 15 days after receipt of a petition for declaratory order, the department shall provide copies of the acknowledgment of receipt and copies of the petition to all persons to whom notice of the petition is required by any provision of law. The department may also give notice to any other persons deemed appropriate.

761—12.4(17A) Action on petition.

12.4(1) A declaratory order or an order declining to issue a declaratory order shall be issued by the director.

12.4(2) The director shall not issue a declaratory order that would substantially prejudice the rights of a person who would be a necessary party and who does not consent in writing to the determination of the matter by a declaratory order proceeding.

12.4(3) The director may issue an order declining to issue a declaratory order on some or all of the questions raised in the petition for any of the following reasons:

- a. The petition does not substantially comply with the required form.
- b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department to issue a declaratory order.
- c. The department does not have jurisdiction over the questions presented in the petition.
- d. The questions presented in the petition are also presented in a current rule-making, contested case, or other agency or judicial proceeding that may definitively resolve them.
- e. The questions presented in the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
- f. The questions posed or facts presented in the petition are unclear, vague, incomplete, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue a declaratory order.
- g. There is no need to issue a declaratory order because the questions raised in the petition have been settled due to a change in circumstances.
- h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a department decision already made.
- i. The petition requests a declaratory order that would necessarily determine the legal rights, duties or responsibilities of other persons who have not joined in the petition or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of the petitioner.
- j. The petitioner requests the department to determine whether a statute is unconstitutional on its face.

12.4(4) If the director issues an order declining to issue a declaratory order, the order must indicate the specific grounds for declining to issue a declaratory order and constitutes final agency action on the petition.

761—12.5(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the department and the petitioner and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final agency action on the petition.

These rules are intended to implement Iowa Code sections 17A.9 and 17A.19.

[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]

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[Filed ARC 4492C (Notice ARC 4325C, IAB 3/13/19), IAB 6/5/19, effective 7/10/19]
[Editorial change: IAC Supplement 7/28/21]

PRIMARY ROAD EXTENSIONS

CHAPTER 150

IMPROVEMENTS AND MAINTENANCE ON PRIMARY ROAD EXTENSIONS

[Prior to 6/3/87, Transportation Department[820]—(06.L) Ch 1]

761—150.1(306) Definitions.

“*Access control limits*” means the area within the primary highway right-of-way limits, including right-of-way lines extended across side streets and roads. The term includes areas on side streets and roads where the department has acquired access control rights in accordance with 761—Chapter 112.

“*City*” means a municipal corporation as defined in Iowa Code section 362.2.

“*Encroachment*” means an item which is supported or located on the highway right-of-way or which overhangs into the airspace of the highway right-of-way.

“*Freeway*” means a primary highway constructed with Priority I access control. For the purpose of highway lighting, “*freeway*” means a primary highway constructed with Priority I access control for a length of five miles or greater.

“*MUTCD*” means the “Manual on Uniform Traffic Control Devices,” as adopted in 761—Chapter 130.

“*Nonfreeway primary highway*” means a primary highway that is not a freeway.

“*Obstruction*” means the same as defined in Iowa Code section 318.1.

“*Right-of-way*” means the land for any public road, street or highway, including the entire area between the property lines.

“*Urban-state traffic engineering program*” or “*U-STEP*” refers to a department program that is intended for use by any Iowa city in order to solve traffic operations and safety problems on primary roads in Iowa cities as documented in the department’s “Guide to Transportation Funding Programs.”

“*Utility*” means the same as defined in Iowa Code section 306A.13.

This rule is intended to implement Iowa Code sections 306.2, 306.3, 306A.13, 318.1 and 362.2.
[ARC 3501C, IAB 12/6/17, effective 1/10/18]

761—150.2(306) Improvements and maintenance on extensions of freeways.

150.2(1) Construction. Except as otherwise provided, the department shall be responsible for all right-of-way and construction costs associated with the construction of freeway extensions.

a. The city shall be responsible for providing, without cost to the department, all necessary rights-of-way that involve dedicated streets or alleys.

b. The city may be responsible for providing, without cost to the department, all necessary rights-of-way that involve other city-owned lands, except parklands, subject to the condition that the department may reimburse the city for the functional replacement value of improved property and advanced purchases negotiated by the city for project purposes.

c. Outside the access control limits, the department shall be responsible for the costs of construction of longitudinal and outlet storm sewers made necessary by highway construction in the proportion that the street right-of-way of the primary road extension bears to the total drainage area to be served by the proposed sewers. The city shall be responsible for the remaining portion of storm-sewer costs not paid for by the department.

d. The department shall be responsible for all storm sewer-related costs within the access control limits.

150.2(2) Maintenance. The department shall enter into an agreement with a city regarding the maintenance of primary roads within the corporate city limits. This is intended to include corporate line roads, when appropriate. Unless otherwise mutually agreed to and specified in the agreement, the maintenance of freeway extensions within the corporate city limits, including corporate line roads, shall be as follows:

a. The department shall be responsible for all maintenance costs on the through roadway, the on and off ramps, and the roadside features from right-of-way line to right-of-way line.

b. Where city streets cross the freeway, the department shall be responsible for:

- (1) Roadside maintenance within the limits of the freeway fence.
- (2) Surface drainage of the right-of-way.
- (3) Traffic signs and pavement markings required for freeway operation.
- (4) Guardrail at piers and bridge approaches.
- (5) Expansion relief joints in approach pavement and leveling of bridge approach panel(s).
- (6) All maintenance of bridges including deck repair, structural repair, berm slope protection, painting, and inspection, except as noted in paragraph "c" of this subrule.
 - c. Where city streets cross the freeway, the city shall be responsible for:
 - (1) All roadside maintenance outside the freeway fence.
 - (2) All pavement, subgrade and shoulder maintenance on the cross street except expansion relief joints and bridge approach panel leveling.
 - (3) All traffic lane markings on the cross street.
 - (4) Snow removal on the cross street including bridges over the freeway.
 - (5) Cleaning and sweeping bridge decks on streets crossing over the freeway.
 - d. The city shall be responsible for maintenance and repair of pedestrian overpasses and underpasses including snow removal, painting, lighting and structural repairs.
 - e. Should local service roads or streets be constructed as a part of a project, upon completion they shall become a part of the city street system. The department shall not be responsible for the maintenance of these roads or streets and corresponding drainage structures.

150.2(3) Lighting.

- a. The department shall be responsible for the cost of installation of lighting on the main-traveled-way lanes and the on and off ramps including the terminals with cross streets when the department determines that lighting is required under established warrants.
- b. The department shall be responsible for the energy and maintenance costs of lighting on the main-traveled-way lanes.
- c. The department shall be responsible for the energy and maintenance costs of lighting through interchange areas and ramps at interchanges between freeways which do not provide service to local streets.
- d. The department shall be responsible for the energy and maintenance costs of lighting in interchange areas at interchanges between freeways and primary roads which are on corporate lines.
- e. At interchanges with city cross streets, the department shall be responsible for the energy and maintenance costs of lighting on the main-traveled-way lanes, on and off ramps, ramp terminals, and, when the department determines full interchange lighting is required, the cross street between the outermost ramp terminals.
- f. The department shall not be responsible for the installation, energy, and maintenance costs of any lighting on cross streets in advance of interchanges and between the outermost ramp terminals at interchanges where the department determines partial interchange lighting or no lighting is required.
- g. The department shall not be responsible for the installation, energy and maintenance costs of any lighting on pedestrian overpasses, pedestrian underpasses, bicycle overpasses or bicycle underpasses. The city may elect to provide lighting at its own expense.
- h. Warrants for the lighting of freeways shall be according to the 2005 "AASHTO Roadway Lighting Design Guide."

150.2(4) Traffic signals at ramp terminals with cross streets.

- a. All traffic signal installations shall meet the standards and warrants established in the MUTCD.
- b. On projects initiated by the department, the department may install, at no cost to the city, traffic signals warranted when replacing existing pavement or adding new lanes. In conjunction with these projects, the department may also participate in the cost of signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment.
- c. When new pavement construction or additional lanes are not involved, the department may participate in the installation costs of new and modernized traffic signals or signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on

the current U-STEP cost apportionment; the city shall prepare plans, award the contract, supervise the installation, and be responsible for the remaining installation costs.

d. Modifications made to the traffic signal system to coordinate it with other city signal systems (not on the primary road extension system) shall be the sole financial responsibility of the city.

e. The department shall not assume ownership and shall not be responsible for the energy and maintenance costs involved in the operation of traffic signals.

f. Signal phasing, initial and future, as well as timing and coordination between intersections shall be coordinated between the department and the city.

This rule is intended to implement Iowa Code sections 306.4, 306.42, 313.4, 313.5, 313.21 to 313.24, 313.27, 313.36, 314.5 and 314.6 and chapter 306A.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21]

761—150.3(306) Improvements and maintenance on extensions of nonfreeway primary highways.

150.3(1) Construction.

a. The department shall be responsible for all right-of-way and construction costs to construct nonfreeway primary highway extensions to the minimum design criteria as established by the department. Construction improvement costs beyond minimum design criteria shall be the responsibility of the city, as specified in the project agreement. Minimum design criteria shall be in accordance with “A Policy on Geometric Design of Highways and Streets, 2018” (Seventh Edition AASHTO Green Book).

b. The city shall be responsible for providing, without cost to the department, all necessary rights-of-way that involve dedicated streets or alleys.

c. The city may be responsible for providing, without cost to the department, all necessary rights-of-way that involve other city-owned lands, except parklands, subject to the condition that the department may reimburse the city for the functional replacement value of improved property and advanced purchases negotiated by the city for project purposes.

d. The city shall take all necessary legal action to discontinue and prohibit any past or present use of project rights-of-way for private purposes. The city shall prevent any future encroachment or obstruction within the limits of project rights-of-way.

e. The department shall be responsible for the costs of construction of longitudinal and outlet storm sewers made necessary by highway construction and construction of local service roads developed as a part of the construction or reconstruction of the through traffic lanes in the proportion that the right-of-way of the primary road extension bears to the total drainage area to be served by the proposed sewers. The city shall be responsible for the remaining portion of storm-sewer costs not paid for by the department.

f. Unless otherwise mutually agreed to and specified in the project agreement, the department shall be responsible for the cost of acquiring rights-of-way and construction of local service roads developed as a part of the construction or reconstruction of the through traffic lanes.

150.3(2) Maintenance. The department shall enter into an agreement with a city regarding the maintenance of primary roads within the corporate city limits. This is intended to include corporate line roads, when appropriate. Unless otherwise mutually agreed to and specified in the agreement, the maintenance of nonfreeway primary highway extensions within the corporate city limits, including corporate line roads, shall be as follows:

a. On primary roads constructed with a curbed cross section, the department shall be responsible for:

(1) Maintenance and repairs to pavement and subgrade from face of curb to face of curb exclusive of parking lanes, culverts, intakes, manholes, public or private utilities, sanitary sewers and storm sewers.

(2) Primary road signing for moving traffic as set out in subrule 150.4(1), pavement markings for traffic lanes, guardrail and stop signs at intersecting streets.

(3) Surface drainage only, within the limits of pavement maintenance.

(4) Plowing of snow from the traffic lanes of pavement and bridges and treatment of traffic lanes with abrasives and chemicals.

(5) Inspection, painting and structural maintenance of bridges as defined in Iowa Code section 309.1.

b. On primary roads constructed with a rural cross section (no curb), the department shall be responsible for all maintenance, except tree removal, sidewalks, retaining walls and repairs due to utility construction and maintenance shall be the city's responsibility.

c. On primary roads constructed with a curbed cross section, the city shall be responsible for:

(1) Maintenance and repairs to pavement in parking lanes, intersections beyond the limits of department pavement maintenance, curbs used to contain drainage, and repairs to all pavement due to utility construction, maintenance and repair.

(2) Painting of parking stalls, stop lines and crosswalks, and the installation and maintenance of flashing lights. Pavement markings shall conform to the MUTCD.

(3) Maintenance of all storm sewers, manholes, intakes, catch basins and culverts used for collection and disposal of surface drainage.

(4) Removal of snow windrowed by departmental plowing operations, removal of snow and ice from all areas outside the traffic lanes, loading or hauling of snow which the city considers necessary and removal of snow and ice from sidewalks on bridges used for pedestrian traffic.

(5) Maintenance of sidewalks, retaining walls and all areas between curb and right-of-way line.

(6) Cleaning, sweeping and washing of streets.

(7) Maintenance and repair of pedestrian overpasses and underpasses including snow removal, painting and structural repairs.

(8) Maintenance and repair of bicycle overpasses and underpasses including snow removal, painting and structural repairs.

d. The city shall comply with the access control policy of the department as adopted in 761—Chapter 112 and obtain prior approval from the department for any changes to existing entrances or for the construction of new entrances.

e. Drainage district assessments levied against the primary road within the corporate limits of the city shall be shared equally by the department and the city.

f. Should local service roads or streets be constructed as a part of a project, upon completion they shall become a part of the city street system. The department shall not be responsible for the maintenance of these roads or streets and corresponding drainage structures.

150.3(3) *Lighting.*

a. The department shall not be responsible for the installation, energy, and maintenance costs of lighting on extensions of nonfreeway primary highways. The city may elect to provide lighting at its own expense. However:

(1) For cities with a population of 5,000 or less, the department may elect to install interchange lighting and to be responsible for or to participate in the energy and maintenance costs of this lighting.

(2) On a new construction project that results in a predominately fully controlled access highway, but incorporates some nonfreeway segments, the department may elect to participate in the installation of lighting at conflict points if the city agrees to be responsible for the energy and maintenance costs of this lighting.

b. At corporate line primary road junctions, the lighting shall be installed where necessary by the department in accordance with department warrants. The department shall be responsible for the installation costs. Unless otherwise agreed, the energy and maintenance costs shall be shared by the city and department in proportion to the number of luminaires in each jurisdiction as established by the corporate line. When and if the corporate line is extended to include any part of the lighting installation or a greater proportion of luminaires, the proportionate costs for maintenance and energy shall be redetermined on the basis of the number of luminaires in each jurisdiction as established by the new location of the corporate line.

150.3(4) *Traffic signals.*

a. All traffic signal installations shall meet the standards and warrants established in the MUTCD.

b. On projects initiated by the department, the department may install, at no cost to the city, traffic signals warranted when replacing existing pavement or adding new lanes. In conjunction with these

projects, the department may also participate in the cost of signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment.

c. When new pavement construction or additional lanes are not involved, the department may participate in the installation costs of new and modernized traffic signals or signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment; the city shall prepare plans, award the contract, supervise the installation, and be responsible for the remaining installation costs.

d. Modifications made to the traffic signal system to coordinate it with other city signal systems (not on the primary road extension system) shall be the sole financial responsibility of the city.

e. The department shall not participate in the cost of signals for commercial use only.

f. The department shall not participate in the signalization of primary road stub routes which terminate within the city.

g. The department shall not assume ownership and shall not be responsible for any energy or maintenance costs for traffic signals.

h. Signal phasing, initial and future, as well as timing and coordination between intersections shall be coordinated between the department and the city.

150.3(5) *Overdimensional and overweight vehicles.* The city shall comply with all current statutes, rules and regulations pertaining to overdimensional and overweight vehicles using primary roads when issuing special permits for overdimensional and overweight vehicles.

This rule is intended to implement Iowa Code sections 306.4, 306.42, 313.5, 313.21 to 313.24, 313.27, 313.36, 314.5, 314.6 and 321E.3 and chapter 306A.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21]

761—150.4(306) General requirements for primary road extensions.

150.4(1) *Signing.*

a. The department shall be responsible for permanent traffic control signing on primary road extensions.

b. The department shall not be responsible for construction and maintenance work zone signing unless the work is being done by the department.

c. The department shall not be responsible for street name signs, any regulatory parking signs which denote special regulations as may be determined by the city in cooperation with the department, and those signs which regulate parking as to time, hours and days of the week.

d. The department shall not be responsible for signs facing traffic on primary road extensions which regulate traffic movements on city cross streets (one-way traffic).

e. "Business District" signs on primary road extensions may be permitted upon application by the city to the department.

f. All signing within the right-of-way shall conform to the MUTCD.

150.4(2) *Encroachments and obstructions.*

a. The city shall remove any existing obstructions within the highway right-of-way and prevent any future obstructions from occurring within the highway right-of-way, in a manner consistent with Iowa Code chapter 318.

b. The city shall remove any existing encroachments and prevent any future encroachments from occurring within the highway right-of-way, except those authorized or permitted by the highway authority. Under no circumstances shall an overhanging sign or awning be allowed within two feet of the inside edge of the curb (also known as the face of the curb, which is that part of the curb that is next to traffic) or within two feet of the edge of the pavement in the absence of a curb. Any encroachments authorized or permitted by the highway authority shall be in accordance with Iowa Code chapter 318.

150.4(3) *Pedestrian, equestrian, and bicycle routes (sidewalks).*

a. The department shall remove and replace portions of existing routes as required by construction.

b. The department will consider the impacts to pedestrian accommodation at all stages of the project development process and encourage pedestrian accommodation efforts when pedestrian

accommodation is impacted by highway construction. The cost of pedestrian accommodation made at the time of the highway improvement may be considered an additional roadway construction cost. Providing pedestrian accommodation independent of a highway construction project may be considered with construction funding obtained from local jurisdictions or other federal and non-road use tax state sources.

c. If a project is initiated by the department, the department shall fund 100 percent of all curb ramps, turning spaces, transitions, sidewalks, curb drops and pedestrian signals within the right-of-way of primary road extensions to meet the requirements of the Americans with Disabilities Act if such improvements are in the project.

d. If a project is initiated by a local jurisdiction, the department may participate by funding 55 percent of the cost of constructing curb ramps, turning spaces, transitions, sidewalks, curb drops and pedestrian signals on existing sidewalks within the right-of-way of primary road extensions to meet the requirements of the Americans with Disabilities Act if such improvements are in the project. However, departmental participation shall not exceed \$250,000 per year for any one local jurisdiction and \$5 million per year in total.

150.4(4) *Overpasses and underpasses for pedestrian, equestrian, and bicycle routes.*

a. During initial construction of freeways and other relocated primary road extensions and when user-volumes and topographic conditions warrant the construction of a separation, the cost shall be shared between the department and the city on the basis of the current U-STEP cost apportionment.

b. The department may participate in a city-initiated separation as an unscheduled project.

150.4(5) *Utility relocation and removal.*

a. The city shall relocate or cause to be relocated, without cost to the department, all city-owned utilities necessary for construction when these utilities are within the existing street or alley right-of-way. The department shall reimburse the owner of a utility which is located on private right-of-way for the costs of relocation or removal, including the costs of installation in a new location.

b. The city shall comply with the utility accommodation policy of the department, as adopted in 761—Chapter 115.

150.4(6) *Project concept statements and predesign project agreements for proposed construction projects.*

a. As early as possible after an urban project is included in the department's "Five-Year Iowa Transportation Improvement Program," a concept statement for the project shall be developed and shall be reviewed with the officials of the city prior to the public hearing.

b. During the design process, a predesign project agreement may be submitted to city officials for their approval. It shall include:

- (1) A preliminary description of the project,
- (2) The general concepts of the project,
- (3) Responsibilities for right-of-way acquisition, storm sewer costs and utility adjustment costs,
- (4) The parking and access control restrictions to be applied to the project, and
- (5) Financial participation above minimum standards.

150.4(7) *Preconstruction project agreements for proposed construction projects.*

a. The department shall maintain a close liaison with the city during the development of the project plan so that all parties will be fully informed of the details involved in the proposed improvement.

b. When the plan is sufficiently complete to provide typical cross sections, plan and profile drawings and incidental details, the department shall submit a preconstruction project agreement, which shall include known design data, to city officials for their approval. Terms for reimbursement to the state and local financial participation shall be stated in this agreement.

c. Modifications to this agreement necessitated by design changes encountered during construction shall be made by extra work order agreed to in writing by the city, the contractor, and the department.

This rule is intended to implement Iowa Code sections 306.4, 313.21 to 313.24, 313.27, 313.36, 314.5 and 314.6 and chapters 306A and 318.

[ARC 0478C, IAB 12/12/12, effective 1/16/13; ARC 3501C, IAB 12/6/17, effective 1/10/18]

761—150.5(307) Special circumstances.

150.5(1) *Waivers.* The director of transportation may, in response to a written petition, waive provisions of this chapter in accordance with 761—Chapter 11. The written petition must contain the information as required in 761—subrule 11.5(2) and shall be submitted to the Rules Administrator, Government and Community Relations, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or by email to the rules administrator’s email address listed on the department’s website at iowadot.gov/administrativerules.

150.5(2) *Waivers involving interstate highways.* The director of transportation shall not waive these rules if the request involves the interstate highway system, including its ramps, without the approval of the Federal Highway Administration.

This rule is intended to implement Iowa Code sections 17A.9A and 307.12.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21; Editorial change: IAC Supplement 7/28/21]

[Filed 7/1/75]

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[Filed ARC 3501C (Notice ARC 3367C, IAB 10/11/17), IAB 12/6/17, effective 1/10/18]

[Filed ARC 5427C (Notice ARC 5244C, IAB 11/4/20), IAB 2/10/21, effective 3/17/21]

[Editorial change: IAC Supplement 7/28/21]

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING

The Iowa commission of veterans affairs hereby adopts, with the following exceptions and amendments, the Uniform Administrative Rules pertaining to procedures for agency rule making which are printed in the first Volume of the Iowa Administrative Code.

801—4.3(17A) Public rule-making docket.

4.3(2) In lieu of the words “(commission, board, council, director)”, insert “Iowa commission of veterans affairs”.

801—4.4(17A) Notice of proposed rule making.

4.4(3) In lieu of the words “(specify time period)”, insert “one year”.

801—4.5(17A) Public participation.

4.5(1) In lieu of the words “(identify office and address)”, insert “the office of the executive director. This office is located in Building 3465 at Camp Dodge, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824”.

[ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—4.6(17A) Regulatory flexibility analysis.

4.6(3) In lieu of the words “(designate office)”, insert “the office of the executive director. This office is located in Building 3465 at Camp Dodge, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824”.

[ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—4.11(17A) Concise statement of reasons.

4.11(1) General.

In lieu of the words “(specify office and address)”, insert “the office of the executive director. This office is located in Building 3465 at Camp Dodge, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824”.

[ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—4.13(17A) Agency rule-making record.

4.13(2) Contents.

In lieu of the words “(agency head)”, insert “chairperson of the commission of veterans affairs”.

801—4.14(17A,35D) Uniform waiver rule.

4.14(1) To the extent a waiver or variance is consistent with applicable statute, constitutional provision, or other provision of law, the commission of veterans affairs may issue an order, in response to the timely filing of a completed petition or on its own motion, granting a waiver or variance, in whole or in part, from the requirements of a rule under the jurisdiction of said commission, as applied to the circumstances of a specified person, if the commission finds clear and convincing evidence of all of the following:

a. The application of the rule to the person at issue would result in undue hardship to that person; and

b. The provisions of a rule subject to a petition for a waiver or variance are not specifically mandated by statute or another provision of law; and

c. The waiver of the rule in the specific case would not prejudice the substantial legal rights of any person; and

d. Substantially equal protection of public health, safety and welfare will be afforded by a means other than that prescribed in the rule for which the waiver or variance is requested.

The decision on whether the circumstances justify the granting of a waiver or variance shall be made at the discretion of the chairperson of the commission of veterans affairs based on the unique, individual circumstances set out in the petition and upon consideration of all relevant factors.

4.14(2) A waiver or variance, if granted, shall be drafted by the commission so as to provide the narrowest exception possible to the provisions of the rule. The commission may place any condition on a waiver or variance that the commission finds desirable to protect the public health, safety and welfare. A waiver or variance shall not be permanent, unless the petitioner can show that a temporary waiver or variance would be impracticable. If a temporary waiver or variance is granted, there is no automatic right to renewal. At the sole discretion of the agency, a waiver or variance may be renewed if the agency finds that all of the factors set out in subrule 4.14(1) remain valid.

4.14(3) The burden of persuasion rests with the person who petitions the commission for the waiver or variance of a rule.

4.14(4) This uniform waiver rule shall not preclude the commission from granting waivers or variances in other contexts or on the basis of other standards if the statute or other rules authorize it to do so and the commission deems it appropriate to do so.

801—4.15(17A,35D) Procedures for granting waivers.

4.15(1) Any person may file a petition with the commission of veterans affairs requesting a waiver, in whole or in part, of a commission rule on the grounds that the application of the rule to the particular circumstances of that person justifies a waiver under this uniform waiver rule. The commission chairperson shall receive written petitions.

4.15(2) A petition for a waiver shall include the following information where applicable and known to the person requesting the waiver:

- a.* The name, address, and case number or state identification number of the entity or person for whom a waiver is requested.
- b.* A description and citation of the specific rule from which a waiver is requested.
- c.* The specific waiver requested, including the precise scope and operative period that the waiver will extend.
- d.* The relevant facts that the petitioner believes would justify a waiver. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes will justify a waiver.
- e.* A history of the commission's action relative to the petitioner.
- f.* Any information regarding the commission's treatment of similar cases, if known.
- g.* The name, address, and telephone number of any person inside or outside state government who would be adversely affected by the granting of the petition or who otherwise possesses knowledge of the matter with respect to the waiver request.
- h.* Signed releases of information authorizing persons with knowledge regarding the request to furnish the commission with information pertaining to the waiver.

4.15(3) The procedural guidelines stated under the Iowa Administrative Procedure Act, Iowa Code chapter 17A, shall govern the form, filing, timing and contents of petitions for the waivers of rules and the procedural rights of persons in relation to such petitions.

4.15(4) The commission shall acknowledge a petition upon receipt. The petitioner shall serve notice on all persons to whom notice is required by any provision of law and provide a written statement to the commission attesting that notice has been served.

4.15(5) Prior to issuing an order granting or denying a waiver request, the commission may request additional information from the petitioner relative to the application and surrounding circumstances.

4.15(6) An order granting or denying a request for waiver shall be in writing and contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which that action is based, and a description of the precise scope and operative period of the waiver if one is issued. The commission shall grant or deny a petition for the waiver of all or a portion of a rule as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a waiver petition has been filed in a contested case proceeding, the agency shall grant or deny the petition no later than the time at which the final decision in that contested case is issued. Failure of the commission to grant or deny such a petition within the required time period shall be deemed a denial of that petition by the commission.

4.15(7) Within seven days of its issuance, any order issued under the uniform waiver rule shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

4.15(8) Subject to the provisions of Iowa Code section 17A.3(1) “e,” the commission shall maintain a record of all orders granting and denying requests for waivers under this uniform waiver rule. The records shall be indexed by rule and available for public inspection.

4.15(9) Within 60 days of granting or denying a waiver, the commission shall make a submission on the Internet site established pursuant to Iowa Code section 17A.9A for the submission of waiver information. The submission shall identify the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, a general summary of the reasons justifying the commission’s actions on the waiver requests and, to the extent practicable, detailing the extent to which the granting of a waiver has affected the general applicability of the rule itself and established a precedent for additional waivers.

4.15(10) The provisions of rules 801—4.14(17A,35D) and 801—4.15(17A,35D) shall not apply to rules that define the meaning of a statute or other provisions of law or precedent if the commission does not possess delegated authority to bind the courts to any extent with its definition and do not authorize the commission to waive any requirement created or duty imposed by statute.

4.15(11) After the commission issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is invoked.

[ARC 5815C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code sections 17A.4 and 17A.9A, Iowa Code chapter 35D, and Executive Order Number 11.

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[Filed ARC 5815C (Notice ARC 5655C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]

CHAPTER 10
IOWA VETERANS HOME
[Prior to 2/29/84, Social Services[770] Ch 134]
[Prior to 2/11/87, Human Services[498] Ch 10]
[Prior to 1/20/93, Human Services[441] Ch 10]

PREAMBLE

The Iowa Veterans Home is a long-term health care facility located in Marshalltown, Iowa, with oversight provided by the commission of veterans affairs.

801—10.1(35D) Definitions relevant to Iowa Veterans Home. The following definitions are unique to rules pertaining to the Iowa Veterans Home.

“Acute alcoholic” means any disturbance of emotional equilibrium caused by the consumption of alcohol resulting in behavior not currently controllable.

“Acutely mentally ill” means any disturbance of emotional equilibrium manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biological, psychological, social or cultural factors which requires hospitalization.

“Addicted to drugs” means a state of dependency as medically determined resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

“Admissions committee” means the committee appointed by the commandant to review applications to determine eligibility for admission and appropriate level and category of care.

“Admissions coordinator” means the individual responsible for the coordination of the admissions process.

“Applicant” means a person who is applying for admission into the Iowa Veterans Home.

“Assets” means items of value held by, or on behalf of, an applicant or member. Assets include, but are not limited to, cash, savings and checking accounts; stocks; bonds; contracts for sale of property; homestead or nonhomestead property. Nonrecurring windfall payments such as, but not limited to, inheritances; death benefits; insurance or tort claim settlements; and cash payments received from the conversion of a nonliquid asset to cash shall be considered assets upon receipt.

“At once” or *“timely”* means within ten calendar days.

“Collaborative care plan” means the plan of care developed for a member by the resident care committee.

“Commandant” means the chief executive officer of the Iowa Veterans Home.

“Commission” means the Iowa commission of veterans affairs.

“Continuously disruptive” means any behavior, on a recurring basis, which has been documented by Iowa Veterans Home staff, that causes harm to a member or staff or conflicts with the member responsibilities set forth in subrule 10.12(1).

“Countable asset” means an asset to be considered in calculation of member support obligation.

“Dangerous to self or others” means any activity by a member which would result in injury to the member or others.

“Dependent” means a person for whose financial support an applicant or member is legally responsible or obligated.

“Diversion” means income that is transferred to a spouse before the member support is determined.

“DVA” means the U.S. Department of Veterans Affairs.

“Free time” means 12 days of leave time each calendar year for which the member is not charged for care during absence.

“Full support rate” means the maximum daily rate of support times the billable days of care received in any month less any offsets.

“Gold Star parent” means a parent of a deceased member of the United States armed forces who died while serving on active duty during a time of military conflict or who died as a result of such service.

“Honorable discharge” means separation or retirement from active military service. The veteran must be eligible for medical care in the DVA system (excluding financial eligibility). Honorable discharge includes general discharges under honorable conditions.

“Income” means money gained by labor or service, or money paid periodically to an applicant or member. Income includes, but is not limited to, disability, retirement pensions or benefits; interest, dividends, payments from long-term care insurance, or other income received from investments; income from property rentals; certain moneys related to real estate contracts; earnings from regular employment or self-employment enterprises.

“IVH” means the Iowa Veterans Home.

“Legal representative” for purposes of applicant or member personal and care decisions means durable power of attorney for health care, guardian, or next-of-kin (spouse, adult children, parents, adult siblings). For applicant or member financial decisions, “legal representative” means conservator, power of attorney, fiduciary or representative payee or next-of-kin (spouse, adult children, parents, adult siblings).

“Licensed nursing home administrator” means a duly licensed nursing home administrator pursuant to Iowa Code chapter 147.

“Medical provider” means a doctor of medicine or osteopathic medicine who is licensed to practice in the state of Iowa. Except as defined by Iowa law, a medical provider also means an advanced registered nurse practitioner or physician assistant who is licensed to practice in the state of Iowa.

“Member” means a resident of IVH.

“Member support” means the dollar amount which is billed monthly to the member or legal representative for the member’s care.

“PASRR” means preadmission screening and resident review.

“Resident care committee” or *“RCC”* means the member, a social worker, a registered nurse, a dietitian, a medical provider, a recreation specialist and a mental health provider, as required, who are involved in reviewing the member’s assessment data and developing a collaborative care plan for the individual member.

“Resource” means assets and income.

“Spouse” means a person who is the legal or common-law wife or husband of a veteran.

“Surviving spouse” means a person who is the legal or common-law widow or widower of a veteran.

“Therapeutic activity” means an activity that is considered as treatment. A therapist shall determine that a particular activity is beneficial to the well-being of a member and shall include this determination in the member’s plan of care.

“Veteran” means a person who served in the active military and who was discharged or released therefrom under honorable conditions. Honorable and general discharges qualify a person as a veteran. The veteran must be eligible for medical care in the DVA system (excluding financial eligibility).

In addition, veteran includes a person who served in the merchant marine or as a civil service crew member between December 7, 1941, and August 15, 1945.

“Visitation” is considered part of the individual’s therapeutic program. Visits are expected to benefit the individual’s treatment goals while meeting the security needs of the facility and ensuring the safety of the individual and visitor.

“Voluntary discharge” means a member wishes to terminate the member’s association with IVH on a permanent basis. This includes discharge for medical reasons which have been approved by a qualified medical provider. All other discharges are involuntary.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.2(35D) Eligibility requirements. Veterans, spouses of veterans, and Gold Star parents shall be eligible for admission to IVH in accordance with the following:

10.2(1) Veterans shall be eligible for admittance to IVH in accordance with the following conditions:

a. The individual is disabled by reason of disease, injury or old age and meets the qualifications for nursing or residential level of care available at IVH.

b. The individual cannot be competitively employed on the day of admission or throughout the individual’s residency.

c. The individual shall have met the residency requirements of the state of Iowa on the date of admission to IVH.

d. An individual who has been diagnosed by a qualified health care professional as acutely mentally ill, as an acute alcoholic, as addicted to drugs, as continuously disruptive, or as dangerous to self or others shall not be admitted to or retained at IVH.

e. The individual must be eligible for care and treatment at a DVA medical center (excluding financial eligibility).

f. Individuals admitted to the domiciliary level of care must meet DVA criteria stated in Department of Veterans Affairs, State Home Per Diem Program, Veterans Health Administration Directive 1610SH.01(1).

g. Homelessness does not disqualify persons otherwise eligible for admission to IVH.

10.2(2) Spouses and surviving spouses shall be admitted in accordance with the following:

a. The spouse or surviving spouse shall have been married to a veteran for at least one year preceding date of application or date of death of veteran.

b. The spouse of a veteran is eligible for admittance to IVH only if the veteran is admitted.

c. The surviving spouse of a deceased veteran is eligible for admittance to IVH if the deceased veteran would also be eligible for admittance to IVH if still living.

d. Spouses, surviving spouses and Gold Star parents admitted to IVH shall not exceed more than 25 percent of the total number of members at IVH as provided in U.S.C. Title 38.

10.2(3) A Gold Star parent shall be eligible for admittance in accordance with the following conditions:

a. The parent's child died while serving on active duty in the armed forces of the United States during a time of military conflict or died as a result of such service.

b. The individual is disabled by reason of disease, injury or old age and meets the qualifications for nursing or residential level of care available at IVH.

c. The individual cannot be competitively employed on the day of admission or throughout the individual's residency.

d. The individual shall have met the residency requirements of the state of Iowa on the date of admission to IVH.

e. An individual who has been diagnosed by a qualified health care professional as acutely mentally ill, as an acute alcoholic, as addicted to drugs, as continuously disruptive, or as dangerous to self or others shall not be admitted to or retained at IVH.

f. Gold Star parents, spouses and surviving spouses admitted to IVH shall not exceed more than 25 percent of the total number of members at IVH as provided in U.S.C. Title 38.

10.2(4) An individual who was not a member of the United States armed forces may be eligible for admittance in accordance with the limitations described in subrule 10.2(1), if the following conditions are met:

a. The individual was a member of the armed services of a nation with which the United States was allied during a time of conflict.

b. The individual is eligible for admission to a DVA medical center in accordance with U.S.C. Title 38, Chapter 17, Medical Care, Subchapter 2, Section 1710.

[ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.3(35D) Application. All applicants shall apply for admission to IVH in accordance with the following subrules:

10.3(1) All applicants shall make application to IVH through the county commission of veterans affairs in the applicant's county of residence.

10.3(2) Application shall be made on the "Veteran Application for Admission to the Iowa Veterans Home," Form 475-0409, the "Spouse's Application for Admission to the Iowa Veterans Home," Form 475-0410, or the "Gold Star Parent Application for Admission to the Iowa Veterans Home," Form

475-2044. Separate applications shall be required for an eligible veteran and the spouse of the veteran when both veteran and spouse are applying for admission. The applications may be obtained at:

- a. The county commission of veterans affairs' office.
- b. DVA medical centers located in or serving veterans in the state of Iowa.
- c. IVH.
- d. Website: ivh.iowa.gov.

10.3(3) The applicant shall provide a copy of a physical which has been completed within three months of application. If needed, a physical examination shall be scheduled by the applicant's primary care provider. Information must be authenticated by the medical provider's original signature or electronic signature.

10.3(4) The following items shall be attached to the application before it is forwarded to IVH:

- a. A copy of the veteran's honorable discharge (DD214) from the armed forces of the United States.
- b. If the applicant is a married or surviving spouse, a copy of the marriage certificate or evidence of a common-law marriage on which a prudent person would rely.
- c. If the applicant is a Gold Star parent, a copy of the child's birth certificate and certification of the child's death while serving on active duty in the armed forces of the United States during a time of military conflict.
- d. A copy of the applicant's birth certificate.
- e. A copy of the marriage license(s), divorce decree(s) or death certificate of the spouse, as applicable.
- f. A completed "Personal Functional Assessment," Form 475-0837.
- g. A completed "Supplement to Application for Admission to the Iowa Veterans Home," Form 475-0843.
- h. A completed "Financial Affidavit," Form 475-0839.

10.3(5) Once the requirements of subrules 10.3(2), 10.3(3) and 10.3(4) have been met, the county commission of veterans affairs shall forward the completed application to the admissions office at IVH. No county shall require additional requirements for the application for admission beyond the requirements stated in these rules. Neither shall a county require additional forms to be filled out or provided by the applicant other than the forms required by these rules.

10.3(6) Eligibility determinations are subject to approval by the commandant or designee.
[ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.4(35D) Application processing.

10.4(1) Applications received by the admissions office shall be reviewed for completeness. The county commission of veterans affairs shall be required to submit additional information if needed.

10.4(2) The admissions committee shall assign the level of care required by the applicant. If a special care unit or treatment is required, this shall be designated. If there is a question regarding the level of care for which the applicant qualifies, the applicant shall be scheduled for either a preadmission visit with appropriate staff or a site visit in order to make a determination of appropriate level of care.

10.4(3) Regardless of whether or not the applicant can be immediately admitted, the applicant shall be notified by the admissions coordinator of the applicant's designated level of care. An applicant who does not wish to be admitted to the designated level of care may submit evidence to show that another level of care may be more appropriate. However, once the admissions committee makes a final determination, the applicant who does not wish to be admitted under the designated level of care may withdraw the application or have the application denied.

10.4(4) When space is not immediately available in the level of care assigned or on the appropriate special care unit, the applicant's name shall be placed on the appropriate waiting list for that level of care or special care unit in the order of the date the application was received.

10.4(5) When space is available at time of application, or when space becomes available in accordance with the designated waiting list, the applicant shall be scheduled for admittance to IVH as follows:

a. An applicant whose physical examination or personal functional assessment, or both if applicable, was completed more than three months prior to the scheduled date of admittance may be required to obtain another physical examination by a medical provider or complete a current personal functional assessment, or both if applicable. This information shall be reviewed to determine that the applicant is capable of functioning at the previously determined level of care.

b. An applicant who requires a different level of care than previously determined shall be admitted to the level of care required if a bed is available or shall have the applicant's name placed on the waiting list for the appropriate level of care in accordance with the date the original application was received.

c. Prior to an applicant's admission to a nursing care unit, the PASRR shall be received.
[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.5(35D) Applicant's responsibilities. Prior to admission to IVH, the applicant or a person acting on the applicant's behalf shall:

10.5(1) Report any change in the applicant's condition that could affect the previously determined level of care.

10.5(2) Report changes in mailing address, county or state of residency.

10.5(3) Provide additional information, verification or authorization for verification concerning the applicant's circumstances, condition of health, and resources if required.

10.5(4) Participate in a preadmission evaluation for level of care if required.

801—10.6(35D) Admission to IVH.

10.6(1) The applicant shall be notified by the admissions coordinator to appear for admission to IVH.

10.6(2) Upon arrival at IVH, the applicant or legal representative shall meet with the admissions staff for an admission interview.

10.6(3) During the interview, the following items will be reviewed and signed by the applicant or legal representative:

a. Permission for Treatment, Form 475-0814.

b. The "Contractual Agreement," Form 475-1833.

c. The applicant's resources.

d. The member support, billing process and banking services.

10.6(4) An applicant becomes a member at that point in time when the applicant or legal representative signs and dates the "Contractual Agreement," Form 475-1833, or otherwise authorizes, in writing, acceptance of the terms of admittance specified in the Contractual Agreement.

10.6(5) Each member shall be placed on a unit providing the appropriate level of care based on individual needs.

a. A member requiring a subsequent change in placement based on individual care needs shall be transferred to a unit which provides the appropriate level of care within the scope of its licensure.

b. Members shall have priority over new admissions for placement on a unit when a vacant bed becomes available.

10.6(6) Care at IVH shall be provided in accordance with Iowa Code chapter 135C; 481—Chapter 57, Residential Care Facilities; 481—Chapter 58, Nursing Facilities; and DVA State Veterans Homes, Veterans Health Administration, M-5, Part 8, Chapter 2, Procedure for Obtaining Recognition of a State Veterans Home and Applicable Standards, 2.07, Standards for Nursing Care, and 2.08, Standards for Domiciliary Care, November 4, 1992.

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.7 to 10.10 Reserved.

801—10.11(35D) Member rights.

10.11(1) Member rights shall be in accordance with those listed in 481—Chapter 57 for members residing in the residential care facility level of care, those listed in 481—Chapter 58 for members residing in the nursing facility level of care, and those noted in Department of Veterans Affairs, State Veterans Homes, Veterans Health Administration, pertaining to residents of state veterans homes.

10.11(2) A member has the right to share a room with the member's spouse when both members consent to the arrangement.

10.11(3) If a member is incompetent and not restored to legal capacity, or if the medical provider determines that a member is incapable of understanding and exercising these rights, the rights devolve to the member's legal representative.

10.11(4) In some cases, a member may be determined to be in need of an agent by the DVA, the Social Security Administration or a similar funding source. In these cases, the commandant or designee may serve as agent subject to Iowa Code section 135C.24. All rights and responsibilities regarding the financial awards shall devolve to the commandant or designee.

[ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.12(35D) Member responsibilities.

10.12(1) The member or legal representative has the responsibility:

a. To timely report the existence of or changes in the member's income, spouse's income, assets or marital status, including the conversion of nonliquid assets to liquid assets.

b. To apply for all benefits due (such as, but not limited to, Title XIX, DVA pension, DVA compensation, Social Security, private pension programs, or any combination), and accept the available billing programs offered at IVH.

c. To provide information concerning the physical condition and, to the best of the member's knowledge, accurate and complete information concerning present physical complaints, past illnesses, hospitalizations, medications and other matters related to the member's health.

d. To report unexpected changes in the member's condition to the attending medical provider or other clinician.

e. To participate in treatment planning, cooperate with the treatment team in carrying out the treatment plan, and to participate in the evaluation of the member's care.

f. To be considerate of the rights of other members and staff and control behavior in respect to smoking, noise, and number of visitors.

g. To treat other members and staff with dignity and respect.

h. To respect the property of other members, staff, and IVH. A member or legal representative may be held financially responsible for any property damaged or destroyed by the member.

i. To ask questions about anything that the member may not understand about the member's care or IVH.

j. To accept the consequences of the member's actions if the member refuses treatment or fails to follow prescribed care.

k. To follow the rules and regulations of IVH regarding member care and conduct as set out in subrule 10.40(1).

l. To keep scheduled appointments with staff. If unable to do so, the member is responsible for notifying appropriate staff.

m. To maintain personal hygiene, including clothing, and maintain personal living area based on the member's physical and mental capabilities.

n. To follow all fire, safety and sanitation regulations as established by IVH and applicable regulatory agencies.

o. To provide information and verification of resources. A member or legal representative must fulfill the member support obligation for member health care.

p. To carry Medicare Part B and Medicare Part D insurance if eligible. IVH shall buy the medical insurance portion of Medicare Part B and Medicare Part D if the member is not eligible to receive Medicare under social security.

q. To delegate to IVH the authorization to enroll the member in Medicare Part B and Medicare Part D. The premium shall be deducted from the member's social security or paid monthly with the member's funds.

r. To assign the benefits of Medicare Part B, Medicare Part D and other medical insurances to IVH. The cost of Medicare Part B, Medicare Part D and other medical insurances shall be used as an offset to the aggregate semiannual per diem rate calculation according to the particular level of care as calculated in January and July of each year for the preceding six months and effective March 1 and September 1.

10.12(2) The member or legal representative is responsible for the full payment of the member's support charges within the calendar month that the monthly support bill is received. Failure to pay a monthly support bill within 30 days of issuance may result in discharge from IVH unless prior arrangements have been made.

10.12(3) In those instances when a legal representative is responsible for the handling of the member's resources, the legal representative shall keep any records necessary and provide all information or verification required for the computation of member support as set out in rule 801—10.14(35D). Failure of the legal representative to do so may result in the discharge of the member. In some cases, IVH may act to have the commandant or designee established as the member's fiduciary or agent as set out in subrule 10.11(4). In those cases when a guardian or conservator of a member fails to keep necessary records or provide needed information or verification or to meet the member support obligation, IVH may notify the court of problems and request to establish another individual as guardian or conservator. The conservator of a member shall submit a copy of the annual conservatorship report to IVH.

10.12(4) When a member temporarily needs a level of care that is not offered by IVH, the member shall be referred by IVH medical staff to a DVA medical center or other medical facility.

a. If a member who is treated at a DVA medical center has coinsurance to supplement Medicare, this coinsurance shall be used for the DVA medical center charges. IVH shall be responsible for all DVA medical center charges if the member does not carry coinsurance supplement.

b. If a member chooses a medical facility other than a DVA medical center or other medical facility as referred by IVH medical staff, the member is responsible for costs resulting from care at the medical facility chosen.

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.13 Reserved.

801—10.14(35D) Computation of member support. As a condition of admittance to and residency in IVH, each member is required to contribute toward the cost of that member's care based on that member's resources and ability to pay.

10.14(1) A monthly member support bill shall be sent to the member or legal representative charging the member for care in the previous month with any necessary adjustment for prior months. A member shall be required to pay member support charges from the member's liquid assets and long-term care insurance benefits and from the member's income. The monthly member support charge shall be the billable days, as set out in subrule 10.14(3), multiplied by the appropriate per diem from rule 801—10.15(35D). This amount shall be reduced by any offsets as set out in subrules 10.15(2) and 10.15(3). The member or legal representative shall pay an amount not to exceed the amount calculated based on the resources available for the cost of care as set out in this chapter.

10.14(2) Title XIX residents. If a member is certified as eligible and participating in the Title XIX program, the amount of payment shall be determined by the department of human services income maintenance worker.

10.14(3) Billable days (non-Title XIX). Billable days for members not participating in the Title XIX program shall be counted as follows:

- a. All days in the month for which the member received care (in-house).
- b. All leave days in excess of the 12 free days up through the fifty-ninth leave day. Any leave days in excess of 59 days shall be considered billable, and the member must pay the full support rate, not the amount determined by resources.
- c. The first ten days of each hospitalization. After ten days, IVH assumes the authority to discharge the resident but reserves the right to negotiate an extension to the bed hold, if warranted, in the best interest of the resident and family, at the discretion of the commandant or designee. A hospital stay may occur more than once in a calendar year.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.15(35D) Per diems.

10.15(1) For members not participating in the Title XIX program, the per diem by which the billable days shall be multiplied shall be established as follows:

- a. *Nursing level of care.*
 - (1) The charge for care is the per diem rate calculated in January and July of each year for the preceding six-month period and is submitted by IVH to the Iowa Medicaid enterprise of the department of human services.
 - (2) The updated per diem rate shall be effective semiannually on March 1 and September 1 of each year.
 - (3) Members or financial legal representatives shall be sent a notice one month in advance of the rate change.
- b. *Domiciliary level of care.*
 - (1) The total cost of care per member shall be determined in January and July of each year for the preceding six-month period and calculated in a manner similar to the nursing level of care. This cost shall be the updated per diem rate.
 - (2) The per diem rate shall be adjusted semiannually on March 1 and September 1 of each year.
 - (3) Members or financial legal representatives shall be sent a notice one month in advance of the rate change.

10.15(2) Veteran members for whom IVH receives a per diem from the DVA (under Title 38). IVH shall consider this per diem as a third-party reimbursement to the charge for care and shall be an offset to the member support bill. The offset of the per diem received (billed to DVA) shall be shown as an offset for the month billed. The provisions of 38 U.S.C. 1745(a), which were established by Section 211 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109-461), set forth a mechanism for paying a higher per diem rate for certain veterans who have service-connected disabilities and are receiving nursing home care in state homes. If IVH receives this higher per diem rate from the DVA, the member will not have a support charge from IVH.

10.15(3) The daily per diem charge shall be reduced by an amount equal to the appropriate Medicare Part B and Medicare Part D premiums paid by the enrolled member.

10.15(4) For members carrying other medical insurance upon admission and continuing to carry other medical insurance after admission. The member support charge shall be reduced by an amount equal to the other medical insurance premium.

10.15(5) For members not eligible for Title XIX medical assistance. The member support charge shall be reduced in accordance with subrules 10.15(2), 10.15(3) and 10.15(4), if applicable. The member shall then contribute all remaining available resources up to the charge for care.

Members receiving DVA pension and aid and attendance shall be considered as having used the amount equal to aid and attendance first in payment for their care at IVH.

10.15(6) Payment of support is due within ten business days after the monthly support bill is received or ten business days after the member's last income deposit for that month.

a. If payment is not received by IVH within 30 days following the due date, a notice of discharge may be issued.

b. If there are extenuating circumstances, the member or legal representative should meet with the commandant or designee to work out a schedule of payments.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.16(35D) Assets. The following rules specify the treatment of assets, as defined in rule 801—10.1(35D), in the payment of member support as described in rule 801—10.14(35D). Only liquid assets shall be considered in the payment of member support.

10.16(1) For members who have applied for and are eligible to receive Title XIX medical assistance, rule 441—75.5(249A) shall apply. Financial eligibility for Title XIX shall be determined by the department of human services income maintenance worker.

10.16(2) For members not eligible for Title XIX medical assistance, the following rules apply:

a. Assets considered. The assets considered shall include all assets owned by the member, or if married, both the member and the spouse living in the community, except for the following:

(1) The homestead is exempt as follows: The exempt homestead is defined as the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. Contiguous means that portions of the homestead cannot be separated from the home by intervening property owned by others. However, the homestead is considered contiguous if portions of it are separated from the home only because of roads or other public rights-of-way. Property that is not exempt as part of the homestead shall be treated in accordance with the rules of this chapter.

The homestead, as defined, can retain its exempt status for a period of time not to exceed 36 months, while the member, spouse and dependents are temporarily absent, provided the following conditions are met:

1. There is a specific purpose for the absence.
2. The member, spouse or dependents intend to return to the homestead when the reason for the absence has been accomplished.

3. The member, spouse or dependents can reasonably be expected to return to the home during the 36-month time limitation.

4. If a person is an applicant at the time the homestead becomes vacant due to the absence of the applicant, spouse or dependents, the first month of the 36-month period is the month of admission to IVH.

5. If a person is a member when the homestead becomes vacant due to the absence of the member, spouse or dependents, the first month of the 36-month period is the month following the month in which the homestead is vacated.

6. Any homestead that does not qualify for this exemption or any homestead that is vacant for a period of time exceeding the 36-month limit shall be treated in accordance with subrule 10.16(3).

(2) Household goods, personal effects and one motor vehicle.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of the member, spouse or any other member of the immediate family.

(4) Exempt income-producing property includes, but is not limited to, tools, equipment, livestock, inventory and supplies, and grain held in storage.

(5) Other property essential to the means of self-support of either the member or spouse as to warrant its exclusion under the Supplemental Security Income program.

(6) Assets of a blind or disabled person who has a plan for achieving self-support as determined by the division of vocational rehabilitation or the department of human services.

(7) Assets of Native Americans belonging to certain tribes arising from judgment fund and payments from certain land and subsurface mineral rights. This does not include per capita payments from casino proceeds.

(8) Any amounts arising from Public Law 101-239 which provides assistance to veterans under the Agent Orange product liability litigation.

(9) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute as a result of a presidential disaster declaration and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(10) An amount that is irrevocable and separately identifiable, having a principal amount not in excess of a predetermined amount set by the department of human services, without an itemized billing, for the member or spouse to meet the burial and related expenses of that person.

(11) Federal assistance paid for housing occupied by the spouse living in the community.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a member or spouse comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

(14) Any other asset excluded by statute.

b. Assets of a single member. When liquid assets not exempted in paragraph “a” above are equal to or exceed \$2,000, those liquid assets shall be considered an available resource for the payment of member support. These assets shall be considered available for payment of member support until such time that the remaining liquid assets total less than \$500, but leaving at least \$140.

c. Assets of a married member with spouse in a care facility. If a member’s spouse is residing in a nursing facility, the member shall be treated as a single member for asset determination purposes. If the member and the spouse become members of IVH on the same day, all resources of both members shall be added together and split one-half to each member for asset determination purposes. If the spouse is residing in a residential care facility or an assisted living facility, the rules pertaining to a spouse living in the community apply.

d. Assets of a married member with spouse living in the community. When liquid assets not exempted in paragraph “a” above are equal to or exceed \$2,000, those liquid assets shall be considered an available resource for the payment of member support.

The assets attributed to the member shall be determined from the documented assets of both the member and spouse living in the community as of the first day of admission to IVH. All resources of both the member and the spouse shall be added together. If the total resources are less than the predetermined amount set by the department of human services, then that amount is awarded to the community spouse. The amount in excess of this predetermined figure, up to an equal amount, if applicable, shall be awarded to the member. Any resources over this combined amount shall be split one-half to the member and one-half to the spouse up to a predetermined maximum amount set by the department of human services. All resources over the predetermined maximum amount shall be awarded to the member. These assets shall be considered available for payment of member support until such time that the remaining liquid assets total less than \$500, but leaving at least \$140.

(1) If the member has transferred assets to the spouse living in the community under a court order for the support of the spouse, the amount transferred shall be the amount attributed to the spouse to the extent it exceeds the specified limits above.

(2) After the month in which the member is admitted, no attributed resources of the spouse living in the community shall be deemed available to the member during the continuous period in which the member is at IVH. Resources which are owned wholly or in part by the member and which are not transferred to the spouse living in the community shall be counted in determining member support. The assets of the member shall not count for member support to the extent that the member intends to transfer and does transfer the assets to the spouse living in the community within 90 days.

(3) Report of results. The department of human services shall provide the member and spouse and legal representative, if applicable, a report of the results of the attribution. The report shall state that either has a right to appeal the attribution in accordance with rule 801—10.45(35D).

e. Exception based on estrangement. When it is established by a disinterested third-party source and confirmed by the commandant or designee that the member is estranged from the spouse living in the community, member support shall be determined on the basis of resources of a single member.

10.16(3) When a member owns an available, nonliquid, nonexempt asset, the value of which would affect the computation of member support as described in rule 801—10.14(35D), the asset shall be liquidated. The value of that asset shall be considered in the computation of member support. The following paragraphs are to be considered when liquidating assets:

a. Net market value, or equity value, is the gross price for which property or an item can be sold on the open market less any legal debts, claims or liens against the property or item. IVH shall consider the condition and location of an item or property and local market conditions in determining the gross sales price of the item or property. In order for a loan or claim to be considered a lien or encumbrance against an asset, the loan or claim must be made under circumstances that result in the creditors having a recorded legal right to satisfy the debt.

b. An asset must be available in order for it to be treated in accordance with the rules of this chapter. An asset is considered available when:

(1) The member owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold or otherwise used and disposed of at the member's discretion; and

(2) The member has a legal interest in a liquidated sum and has the legal ability to make the sum available for member support.

c. A member must take all appropriate action to gain title and control of any asset of which the value would affect the computation of member support.

d. The value of the asset may be adjusted if the member or legal representative:

(1) Advertises the asset for sale, through appropriate methods, on a continual basis.

(2) Lists the asset with a real estate broker or other agent appropriate to the asset.

(3) Asks a reasonable price which is consistent with the asking price of similar items of property in the community.

(4) Does not refuse a reasonable offer.

(5) Does not sell the asset for an unreasonably low price.

e. Cash proceeds from the sale of an asset, conversion of an asset to cash, or receipt of any cash asset as defined in rule 801—10.1(35D) shall be used in the computation of member support beginning with the calendar month of receipt.

[**ARC 8014B**, IAB 7/29/09, effective 7/10/09; **ARC 9689B**, IAB 8/24/11, effective 9/28/11; **ARC 2675C**, IAB 8/17/16, effective 9/21/16; **ARC 5800C**, IAB 7/28/21, effective 9/1/21]

801—10.17(35D) Divestment of assets.

10.17(1) “Intentional divestment of assets” means:

a. To knowingly sell, give or transfer by member or legal representative for less than fair market value, any asset, the value of which would affect member support; or

b. To knowingly and voluntarily place an asset, the value of which would affect member support, under a trust or other legal instrument that ends or limits the availability of that asset.

10.17(2) Transfers of resources shall be presumed to be divestiture unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose. In addition to giving away or selling assets for less than fair market value, examples of transferring resources include, but are not limited to, establishing a trust, contributing to a charity or other organization, removing a name from a joint bank account, or decreasing the extent of ownership interest in a resource or any other transfer as defined in the Supplemental Security Income program.

a. Convincing evidence to establish that the transaction was not a divestiture may include documents, letters, and contemporaneous writings, as well as other circumstantial evidence.

b. In rebutting the presumption that the transfer was a divestiture, the burden of proof is on the individual to establish:

(1) The fair market value of the compensation;

(2) That the compensation was provided pursuant to an agreement, contract, or expectation in exchange for the resource; and

(3) That the agreement, contract, or expectation was established at the time of transfer.

10.17(3) An applicant or legal representative shall not knowingly and intentionally divest an asset, as set out in subrule 10.17(1), within the period established by Title XIX statute prior to admission, with the intention of reducing the applicant's member support or of obtaining admission to IVH.

When it is determined by the commandant or designee that an applicant did intentionally divest an asset, upon admission that applicant may be charged member support as if the divestment did not occur.

10.17(4) A member or legal representative shall not knowingly and intentionally divest an asset, as described in subrule 10.17(1), while a member with the intention of reducing the member support.

When it is discovered that a member or legal representative improperly divested an asset(s), that member may be charged member support as if the divestment did not occur.

[ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.18(35D) Commencement of civil action. The commandant or designee may file a civil action for money judgment against a member or discharged member or the member's legal representative for support charges when the member or discharged member fails to pay member support in accordance with 801—Chapter 10.

801—10.19(35D) Income. This rule describes the treatment of income, as defined at rule 801—10.1(35D), in the computation of member support as described at rule 801—10.14(35D).

10.19(1) For members who are eligible for Title XIX medical assistance, rule 441—75.5(249A) shall apply. For those members participating in the Title XIX medical assistance program, the difference between the \$140 personal needs allowance and the Title XIX personal needs allowance shall be returned to the member out of individual member participation.

10.19(2) For members who are not eligible for Title XIX, the following shall apply:

a. The following types of income are exempt in the computation of member support:

- (1) The earned income of the spouse or dependents.
 - (2) Unearned income restricted to the needs of the spouse or dependents (social security, DVA, etc.).
 - (3) Any other income that can be specifically identified as accruing to the spouse or dependents.
 - (4) Nonrecurring gifts, contributions or winnings, not to exceed \$60 in a calendar quarter.
 - (5) Interest income of less than \$20 per month from any one source.
 - (6) State bonus for military services.
 - (7) Any earnings received by a member for that member's participation in money-raising activities administered by veterans' organizations or auxiliaries (i.e., poppies).
 - (8) Any money received by a member from the sale of items resulting from a therapeutic activity (i.e., items sold in the IVH gift shop).
 - (9) The first \$150 received by a member in a month for participation in the incentive therapy or other programs as described in rule 801—10.30(35D), for members in the domiciliary level of care. For members in the nursing level of care, the first \$75 shall be exempted.
 - (10) Personal loans.
 - (11) In-kind contributions to the member.
 - (12) Title XIX payments.
 - (13) Yearly DVA compensation clothing allowance for those who qualify.
 - (14) Other income as specifically exempted by statute.
 - (15) Any income similar in its origin to the assets excluded in subparagraphs 10.16(2) "a"(6) and (7).
 - (16) Income from employment as outlined in the IVH discharge planning policy (IVH policy #265).
- b.* Personal needs allowance. All members shall have an amount exempted from their monthly income intended to cover the purchase of clothing and incidentals.
- (1) All income up to the first \$140 shall be kept as a personal needs allowance.

(2) The personal needs allowance shall be subtracted from the member's income prior to determination of moneys to which the spouse may be entitled.

c. Any type of income not specifically exempted shall be considered for the payment of member support as provided in rule 801—10.14(35D).

d. Determining income from property.

(1) Nontrust property. Where there is nontrust property, income paid in the name of one person shall be available only to that person unless the document providing income specifies differently. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, the income shall be considered in proportion to their ownership interest. If the member or spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

(2) Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

e. The amount of income to consider in the computation of member support shall be as follows:

(1) Regular monthly pensions and entitlements. The amount of income to be considered is the gross amount of the monthly entitlement or pension received less any medical insurance premium deductions.

(2) Investments or nonrecurring lump sum payments. Net unearned income from investments or nonrecurring lump sum payments shall be determined by deducting income-producing costs from the gross unearned income. Income-producing costs include, but are not limited to, brokerage fees, property manager's salary, maintenance costs and attorney fees.

(3) Property sold on contract. The amount of income to consider shall be the amount received minus any payments for mortgage, taxes, insurance or assessments still owed on the property and payable by the contract holder.

(4) Earned income from a rental, sole or partnership enterprise. The amount of income to consider shall be the net profit figure as determined for the Internal Revenue Service on the member's income tax return.

EXCEPTION: The deductions of the previous year's state and federal taxes and depreciation on the income tax return are not allowable deductions for the purpose of the computation of member support. If a tax return is not available, the member or legal representative shall provide all information and verification needed in order to correctly compute member support.

(5) Partnership income. The member's share of the net profit shall be determined in the same manner as the partnership percentage as determined for the Internal Revenue Service's purposes.

10.19(3) Member income diversion to dependent spouse not living at IVH. A portion of the member's income shall be diverted to the spouse according to the following:

a. Spouse living in the community. One-half the income in exclusion of an amount equal to aid and attendance and after reduction of personal needs allowance.

b. Spouse permanently in another nursing home. Member shall be treated as single. If the member is in receipt of a DVA pension, the amount of income provided the spouse would be the DVA pension dependency amount.

c. Spouses living in a residential care facility. Spouses shall be treated under the same rules as a spouse living in the community in accordance with paragraph 10.19(3) "a."

d. All current court order proceedings and guardian/conservatorship appointments regarding financial obligations shall be honored.

10.19(4) Income disbursements.

a. All diversions to spouse or valid court orders shall be mailed or sent electronically as designated or on a monthly basis.

b. All checks or electronic payments shall be sent to the proper recipient no later than the eighth day of any given month or, at IVH's option, five business days after the member's last income deposit for that month.

c. Monthly income disbursements to a community spouse may be delayed or canceled if there is an overdue amount owed for support payments.

[ARC 7890B, IAB 7/1/09, effective 7/1/09; ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.20(35D) Other income.

10.20(1) When a member receives regular monthly payments of unearned income, it shall be included in the resources available for the payment of member support.

10.20(2) When a member receives periodic recurring income which is received less frequently than monthly, this countable income, after the deduction of any allowable income-producing expenses, shall be considered in the month received.

10.20(3) When a member receives a nonrecurring retroactive payment from a specific entitlement source for a prior period of time, it shall be considered as income in the month received. The aid and attendance amount of the DVA pension shall be computed as a manual adjustment (available to member due to IVH nursing care).

10.20(4) Income from a particular source is considered terminated as of the date the member receives the last income payment from that source or the date that a sole or partnership enterprise ends, whichever is later.

10.20(5) When income from a particular source decreases in a calendar month, the decrease in income shall be considered in the computation of that month's member support. Income from a particular source is considered to be decreased as of the date the member receives the first income payment in the decreased amount.

10.20(6) When income from a particular source increases in a month, the increase in income shall be considered in the computation of that month's member support. Income from a particular source is considered to be increased as of the date the member receives the first income payment in the increased amount.

10.20(7) Recurring lump sum payments shall be treated as income in the month received.

10.20(8) Nonrecurring lump sum payments earned prior to admission, regardless of when received, shall not be counted as income but may be considered as an available liquid asset.

10.20(9) Any income as defined in rule 801—10.20(35D) that exceeds the member support billing for that month shall thereafter be considered a liquid asset available under rule 801—10.16(35D).

10.20(10) Employment is only allowed as identified in the IVH discharge planning policy (IVH policy #265).

[ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter]

801—10.21(35D) Fraud. Applicants, members or legal representatives who knowingly conceal the existence of resources may be subject to the billing of full member support, discharge for failure to pay for member's care or denial of admission. Further, members who knowingly conceal liquid assets or income which would have affected member support shall be charged for the amount not previously billed due to the fraudulent act. If upon admission it is determined that medical or other pertinent information provided during the application process was fraudulent, notice of discharge may be issued. In addition, any applicant, member or legal representative suspected of fraud may be referred to the department of inspections and appeals, division of investigations, for possible criminal or civil action. The attorney general's office shall conduct the investigation.

801—10.22(35D) Overcharges. When it is discovered that a member was charged for support in excess of the amount actually due, the member shall receive a refund or credit to the member's account. If the member is discharged or deceased, a refund shall be conveyed to the member or legal representative.

801—10.23(35D) Penalty.

10.23(1) All members who have resources in excess of the full support rate shall be charged the full support rate. If any member does not apply for all benefits due (such as, but not limited to, Title XIX, DVA pension, DVA compensation, social security, or any combination), fails to report resources

accurately in order to not pay full support, or refuses to accept the available billing programs offered at IVH, that member shall be charged up to full support rate as if these responsibilities had been followed. Failure to comply with these rules may result in discharge from IVH.

10.23(2) If a member is required to pay full member support under these rules, the monthly charge shall be calculated as the per diem in paragraph 10.15(1) “a” or 10.15(1) “b” times the billable days less any offsets. The only exception to this monthly charge will be the additional amount of aid and attendance in the DVA retroactive payment for the time period of nursing care at IVH. This amount, in total, shall be due regardless of resources available. If a member is required to pay member support based on additional resources, these figures shall be obtained from the appropriate agencies.

[ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.24 to 10.29 Reserved.

801—10.30(35D) Incentive therapy and nonprofit rehabilitative programs. Members may be offered the opportunity to perform services for IVH through the incentive therapy program as part of their plan of care. Participating members shall be compensated at the state’s minimum wage for their involvement in the incentive therapy program. If members enrolled in nonprofit rehabilitative programs receive an income from such programs, that income shall be treated in the same manner as the incentive therapy program or IVH policy.

This rule is intended to implement Iowa Code section 35D.7(3).

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.31 to 10.34 Reserved.

801—10.35(35D) Handling of pension money and other funds. Each member who has not been assigned a guardian, conservator, fiduciary or representative payee or has not designated a power of attorney while having adequate decision-making capacity or as otherwise specified may manage that member’s own personal financial affairs. Upon the receipt of written authorization from the member or legal representative by the commandant or designee, the commandant or designee may assist the member in the management of the member’s financial affairs.

10.35(1) Pension money or other funds deposited with IVH are not assignable except as specified at subrule 10.19(3) or 10.40(2) “b”(1).

10.35(2) If authorized by a member, the commandant or designee may act on behalf of that member in receiving, disbursing, and accounting for personal funds of the member received from any source subject to the requirements of Iowa Code section 135C.24. The authorization may be given or withdrawn in writing by the member or legal representative at any time. The authorization shall not be a condition of admission to or retention at IVH.

10.35(3) IVH shall maintain a commercial account with a federally insured bank for the personal deposits of its members. The account shall be known as the IVH membership account/rep payee for social security/VA beneficiaries. The commandant or designee shall record each member’s personal deposits individually and shall deposit the funds in the membership account where the members’ deposits shall be held in the aggregate. Interest shall accrue on those accounts that are on deposit the last working Friday of each month. IVH may withdraw moneys from the account maintained pursuant to this subrule to establish certificates of deposit for the benefit of all members.

10.35(4) If authorized in writing by the member or legal representative, the commandant or designee may make withdrawals against that member’s personal account to pay regular bills and other expenses incurred by the member. The authorization may be given or withdrawn in writing by the member or legal representative at any time. The authorization shall not be a condition of admission to or retention at IVH.

10.35(5) The commandant or designee shall maintain a written record of each member’s funds which are received by or deposited with IVH. The member or legal representative shall receive a monthly statement showing deposits, withdrawals, disbursements, interest and current balances. If

the commandant or designee is made representative payee or fiduciary for the member's financial transactions, this statement shall be maintained in the member's administrative file.

10.35(6) Except as otherwise specified and unless the commandant or designee has been appointed representative payee or fiduciary, funds deposited with IVH shall be released to the member or legal representative upon request. A statement will be provided showing deposits, disbursements, interest, and the final balance at the time the funds are withdrawn. When the member continues to maintain residency at IVH, the funds shall be released and a statement provided within three working days following the request. When a member is being discharged from IVH, the funds shall be released and a statement provided no later than the tenth day of the month following the month of discharge.

10.35(7) Upon the death of a member with personal funds deposited with IVH, and upon receipt of documentation of an outstanding balance, IVH will promptly convey the member's funds to the funeral home or to the individual paying the last funeral expenses. If no bill is presented for funeral expenses, IVH will collect any balance owing for the resident's final support bill, which may include debts owed to the IVH arts and crafts and ceramics program. IVH will notify promptly the estate recovery program of the death of any IVH resident. Upon IVH's receipt of notification from the estate recovery program, any funds remaining in the deceased resident's membership account will be disbursed according to the deceased resident's directions. If probate papers are produced, a final accounting of those funds must also be provided to the individual administering the member's estate along with a disbursement of any remaining funds. If the value of the member's estate is so small as to make the granting of administration inadvisable, IVH must hold, then deliver all money plus interest within one year to the proper heirs equally or adhere to the member's request in the member's last will and testament.

10.35(8) A member discharged while on leave from IVH shall have the member's account closed by the tenth day of the month following discharge.

This rule is intended to implement Iowa Code sections 35D.11(2) and 35D.12(2).

[ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.36(35D) Leave, bed holds and 96-hour passes.

10.36(1) *Non-Title XIX members.*

a. Members are free to leave IVH grounds unless contraindicated by medical determination. In cases where it is determined to be medically contraindicated and a member chooses to leave, the member or legal representative must sign "Discharge Against Medical Advice," Form 475-0940.

b. Leaves are required if the member expects to be absent past midnight.

c. All leaves other than free time shall require payment of member support charges as though the member were in residency. Failure to pay regular member support charges may result in discharge of the member. Leave length may be changed by notification from the member or legal representative to the nursing unit social worker or domiciliary office.

d. Hospital leaves. Leaves spent in approved medical facilities away from IVH shall not be counted against the 59-day leave time limit as set out in paragraph 10.14(3) "b."

Hospital leaves shall be granted and the charges for such leaves shall be as follows: During the first ten consecutive days of any hospital stay, the member shall pay the regular and usual assessed charge for the member's level of care. After the tenth day, if a mutual agreement is made between the resident or legal representative and the commandant or designee for the member's bed to be held for additional days, the member shall not be charged. Each monthly member support bill shall reflect any adjustments related to hospitalization.

Leaves to other medical facilities for the purpose of treatment shall be treated as hospital leaves.

e. General leaves.

(1) Twelve days of leave time each calendar year shall be free time.

(2) The member shall be charged the usual support charge for leave time over 12 days up to and including 59 days.

(3) The member shall be charged the full support rate for the level of care in which the member resides for leave time over 59 days.

(4) Leave time is not cumulative from one calendar year to another calendar year.

(5) Leave time the member has not utilized or cannot utilize shall not be credited toward the member's support.

(6) Support charges for the member on leave who wishes to retain the member's room or bed shall be due and payable as though the member were in residency as set forth in paragraph 10.36(1) "c."

f. When the nursing care member is on leave, the member shall remain on in-house status for the first 12 leave days per calendar year for DVA per diem purposes and IVH shall be financially responsible for medical expenses, which include deductibles, co-pays and the member's share after all insurance has been filed and paid to the medical facility, unless the medical expenses are assumed by the member or legal representative in relation to choice of medical facility.

g. When a member has used 12 non-hospital leave days, IVH is not financially responsible for any medical charges for the member while on leave.

10.36(2) Members who are receiving Title XIX benefits.

a. Members are free to leave IVH grounds unless contraindicated by medical determination. In cases where it is determined to be medically contraindicated and a member chooses to leave, the member or legal representative must sign "Discharge Against Medical Advice," Form 475-0940.

b. A leave as set out in paragraph 10.36(1) "b" is required if a member expects to be absent past midnight.

c. The member's bed shall be held while the member is visiting away from IVH for a period not to exceed 18 days in any calendar year. There is no restriction as to the amount of days taken in any one month or during any one visit, as long as the days taken in the calendar year do not exceed 18. Additional days shall be allowed if the member's medical provider recommends in the plan of care that additional days would be rehabilitative.

d. A member or a legal representative who wishes to exceed the 18 visitation days and retain the member's bed, but does not have medical provider recommendation for an extension, must make arrangements with the operations division administrator or designee for payment of the rate determined by the department of human services income maintenance worker for all days in excess of the 18 visitation days. If prior arrangements and payment are not made, a member may be discharged in accordance with subrule 10.12(2).

e. A bed shall be held for a hospitalized member for up to ten consecutive days. After ten days, IVH assumes the authority to discharge the resident, but reserves the right to negotiate an extension to the bed hold, if warranted, in the best interest of the resident and the facility, at the discretion of the commandant or designee. The member's client participation shall be paid according to the department of human services' income maintenance worker for all hospitalized days until member returns or is discharged.

f. IVH is not financially responsible for any medical charges for the member when visiting away from IVH.

10.36(3) Ninety-six-hour passes for domiciliary members.

a. A pass shall not exceed 96 hours. If a member expects to be gone for more than 96 hours, a leave is required.

b. Upon return from a pass, the member must remain in residence 24 hours before another pass can be issued.

c. When a member is on pass, the member shall remain on in-house status for DVA per diem purposes; IVH shall be financially responsible for medical expenses, which include deductibles, co-pays and the member's share after all insurance has been filed and paid to the medical facility, unless the medical expenses are assumed by the member or legal representative in relation to choice of medical facility.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 8417B, IAB 12/30/09, effective 2/3/10; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.37(35D) Mail.

10.37(1) Each member or legal representative shall be afforded a choice in the methods of handling the member's business mail and in meeting the member's responsibilities for reporting resources for the purpose of computation of member support. A member found to have inadequate financial decision making shall have that member's business mail handled in a manner as to respect that member's dignity and still meet the needs of IVH for complete information regarding resources.

10.37(2) Each member or legal representative shall be allowed to handle that member's business mail to the degree of responsibility chosen by the member or legal representative. A member may:

a. Elect to receive all business mail personally and provide the resident finance office with financial documentation, or

b. Designate that the member shall receive personal mail items, but business mail received at IVH from entitlement sources or concerning assets shall be routed to the resident finance office, cashier's office or purchasing office, whichever is appropriate.

[ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.38 and 10.39 Reserved.

801—10.40(35D) Requirements for member conduct. The commandant or designee shall administer and enforce all requirements for member conduct. Subject to these rules and Iowa Code section 135C.23, the commandant or designee may transfer or discharge any member from IVH when the commandant or designee determines that the health, safety or welfare of the members or staff is in immediate danger, and other reasonable alternatives have been exhausted.

10.40(1) In addition to the member responsibilities as set out in rule 801—10.12(35D), each member shall also comply with the following requirements:

a. The use of intoxicants or alcoholic beverages on IVH premises is prohibited unless prescribed by a medical provider.

b. The bringing of alcoholic beverages or illicit substances on IVH premises is prohibited. Any illicit substances or drug paraphernalia or both found in the member's possession shall be grounds for immediate discharge.

c. The use of illegal substances while a member of IVH is prohibited. A urinalysis shall confirm the presence of illegal substances. A member's refusal to submit to a urinalysis in response to a request based on probable cause shall be considered a positive result and is grounds for discharge.

d. Firearms or weapons of any nature shall be turned in to the commandant or designee for safekeeping. The commandant or designee shall decide if an instrument is a weapon. Firearms or weapons in the possession of a member which constitute a hazard to self or others shall be removed and stored in a place provided and controlled by the facility or sent with family members for safekeeping.

e. Smoking in members' rooms is prohibited. Members who smoke shall do so within designated smoking areas so as not to endanger self or others.

f. Continuously disruptive behavior on the part of a member is grounds for transfer or discharge.

g. Members shall comply with legal requests and orders of the commandant or designee.

h. Members shall not violate state and federal statutes.

i. Members shall report to the resident finance supervisor or designee any changes in assets/income, and pay support within ten business days after the monthly support bill is received or ten business days after the member's last income deposit for the month.

10.40(2) When a member is found in violation of the requirements of conduct established in subrule 10.40(1), the following steps may be taken:

a. For a first offense, a member is counseled by an appropriate staff person and options for correcting the behavior are considered. Options may include but are not limited to:

(1) Funds restriction.

(2) Substance abuse treatment.

(3) Mental health services.

b. IVH control of the member's personal funds as follows:

(1) The pension money and other incomes and available liquid assets shall be deposited by the commandant or designee in a separate account for and on behalf of the member. The commandant or designee shall, under the procedures established in subrules 10.35(3) and 10.35(4), make withdrawals and disbursements to meet the regular bills and other expenses of the member.

(2) If, after a period of up to six months, the member's behavior is deemed appropriate by the facility, the handling of funds will be reviewed, and funds may be returned to the control of the member.

(3) If the member is discharged from IVH, the balance of the funds in the IVH membership account shall be paid to the member or financial legal representative no later than the tenth day of the month following the month of discharge.

c. For a second offense, a member is offered the services above and is placed on probation that warns a third offense may lead to discharge.

d. For a third offense, discharge from IVH in accordance with subrule 10.40(3).

10.40(3) The steps described in subrule 10.40(2) shall generally be followed in that order. However, if the member's violation is of an extreme nature and the member is not amenable to counseling, the commandant or designee shall choose to discharge the member after the expiration of a 30-day written notification period which begins when the notice is personally delivered. If the RCC, in conjunction with the medical provider and mental health personnel, deems that the member's behavior poses a threat of imminent danger, the commandant or designee may issue notice of an immediate involuntary discharge. In such an emergency situation, a written notice shall be given prior to or within 48 hours following the discharge.

The member's county commission of veterans affairs and the legal representative shall be informed in writing of the decision to discharge. Written notification shall also be issued to appropriate governmental agencies including the commission, the department of inspections and appeals, and the department on aging's long-term care ombudsman to ensure that the member's health, safety or welfare shall not be in danger upon the member's release.

10.40(4) A member who has been previously discharged under the provisions of subrule 10.40(2) or 10.40(3) shall be readmitted to IVH only upon the approval of the commandant or designee. If not approved, the applicant shall receive written notice of the denial. A copy of the denial notice shall be forwarded to the commission and the appropriate county commission of veterans affairs. Any decision to deny readmittance is subject to the review of the commission.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.41(35D) County of residence upon discharge. A member does not acquire residency in Marshall County, the county in which IVH is located, unless the member is voluntarily or involuntarily discharged from IVH and the member meets county of residence requirements. For purposes of this rule, "county of residence" means the same as defined in Iowa Code section 331.394.

[ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 4587C, IAB 7/31/19, effective 9/4/19]

801—10.42(35D) Disposition of personal property and funds.

10.42(1) A discharged member shall remove all personal property at the time of discharge or within 30 days. Personal property not removed within 30 days after discharge shall become the property of IVH to dispose of as the commandant or designee directs. Personal property may be forwarded at the member's expense to the member's last-known address. When the member is discharged from IVH, the member's funds shall be released to the member or legal representative with a statement provided no later than the tenth day of the month following the month of discharge.

10.42(2) Following written notification to the legal representative or first next of kin, a deceased member's personal property remaining at IVH 30 days after written notification shall become the property of IVH to dispose of as the commandant or designee directs. If there is a known legal representative or first next of kin, the property may be shipped to the legal representative or first next of kin at the expense of the estate, legal representative, or first next of kin.

10.42(3) Upon the death of a member with personal funds deposited at IVH, after the final bill and any outstanding funeral expenses have been paid, and after receipt of notification from the estate recovery

program (for those on Title XIX) that release of funds is approved, IVH shall convey the member's funds along with a final statement to the legal representative administering the member's estate. When an estate is not opened or in cases where no executor is appointed, IVH shall attempt to locate the deceased member's heirs and deliver the funds to the heirs equally or according to the terms of the last will and testament within one year after the date of death.

[ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.43(35D) Rule enforcement—power to suspend and discharge members. The commandant or designee shall administer and enforce all rules adopted by the commission, including rules of discipline and, subject to these rules, may immediately suspend the membership of and discharge any member from IVH for infraction of the rules when the commandant or designee determines that the health, safety or welfare of the members of IVH is in immediate danger and other reasonable alternatives have been exhausted. The suspension and discharge are temporary pending action by the commission. Judicial review of the action of the commission may be sought in accordance with Iowa Code chapter 17A.

10.43(1) The commandant or designee shall, with the input and recommendation of the RCC, involuntarily discharge a member for any of the following reasons:

a. The member has been diagnosed with a substance use disorder but continues to abuse alcohol or an illegal drug in violation of the member's conditional or provisional agreement entered into at the time of admission or at any time thereafter, and all of the following conditions are met:

(1) The member has been provided sufficient notice of any changes in the member's collaborative care plan.

(2) The member has been notified of the member's commission of three offenses and has been given the opportunity to correct the behavior through either of the following options:

1. Being given the opportunity to receive the appropriate level of treatment in accordance with best practices for standards of care.

2. By having been placed on probation by IVH for a second offense.

Notwithstanding the member meeting the criteria for discharge under paragraph 10.43(1)“*a*,” if the member has demonstrated progress toward the goals established in the member's collaborative care plan, the RCC and the commandant or designee may exercise discretion regarding the discharge. Notwithstanding any provision to the contrary, the member may be immediately discharged under paragraph 10.43(1)“*a*” if the member's actions or behavior jeopardizes the life or safety of other members or staff.

b. The member refuses to utilize the resources available to address issues identified in the member's collaborative care plan, and all of the following conditions are met:

(1) The member has been provided sufficient notice of any changes in the member's collaborative care plan.

(2) The member has been notified of the member's commission of three offenses and the member has been placed on probation by IVH for a second offense.

Notwithstanding the member meeting the criteria for discharge under paragraph 10.43(1)“*b*,” if the member has demonstrated progress toward the goals established in the member's collaborative care plan, the RCC and the commandant or designee may exercise discretion regarding the discharge. Notwithstanding any provision to the contrary, the member may be immediately discharged if the member's actions or behavior jeopardizes the life or safety of other members or staff.

c. The member no longer meets the requirements for residential or nursing level of care, as determined by the RCC or medical provider.

d. The member requires a level of licensed care not provided at IVH.

10.43(2) Provisions for member following discharge from IVH.

a. If a member is discharged under this rule, the discharge plan shall include placement in a suitable living situation which may include but is not limited to a transitional living program approved by the commission or a living program provided by DVA.

b. If a member is involuntarily discharged under this rule, the commission shall, to the greatest extent possible, ensure against the member being homeless and ensure that the domicile to which the

member is discharged is fit and habitable and offers a safe and clean environment which is free from health hazards and provides appropriate heating, ventilation and protection from the elements.

10.43(3) Discharge notice, including right to appeal. An involuntary discharge of a member under this rule shall be preceded by a written notice to the member. The notice shall state that, unless the discharge is an immediate discharge due to the member's actions or behavior which jeopardizes the life or safety of other members or staff, the effective date of the discharge is 30 calendar days from the date of receipt of the discharge notice, and that the member has the right to appeal the discharge. In addition, the discharge notice shall contain:

- a.* The stated reason for the proposed discharge or transfer.
- b.* The actual effective date of the proposed discharge or transfer.
- c.* A statement in not less than 12-point type which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Commission of Veterans Affairs (hereinafter referred to as "Commission") within five (5) calendar days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice at your own expense. If you request a hearing, it will be held, and a decision rendered within ten (10) calendar days of the filing of the appeal. Provision may be made for extension of the ten (10) day requirement upon request to the Commission designee. If you lose the hearing, you will not be discharged or transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than five (5) days following final decision of such hearing. To request a hearing or receive further information, call the Commission or write to the Commission to the attention of: Chairperson, Commission of Veterans Affairs."

10.43(4) Emergency discharge. In the case of an emergency transfer or discharge relating to a threat of imminent harm, the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file, and it must contain all the information required by 10.43(3). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Commission of Veterans Affairs (hereinafter referred to as 'Commission') within 5 calendar days after receiving this notice. If you request a hearing, it will be held and a decision rendered within 10 calendar days of the filing of the appeal no later than 14 days after receipt of your request by the Commission. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, you may call the Commission or write to the Commission to the attention of: Chairperson, Commission of Veterans Affairs."

10.43(5) Appeal by member.

- a.* If a member appeals the discharge under this rule, the member shall be provided with the information relating to the appeals process as specified in rule 801—10.47(35D).

- b.* If a member appeals the discharge under this rule, the involuntary discharge appeal process in rule 801—10.47(35D) shall apply.

10.43(6) By the fourth Monday of each session of the Iowa general assembly, the commandant shall submit a report annually to the senate veterans affairs committee and the house veterans affairs committee specifying the number, circumstances and placement of each member involuntarily discharged from IVH under this rule during the previous calendar year.

10.43(7) Any involuntary discharge by the commandant or designee under this rule shall comply with the rules adopted by the commission and by the department of inspections and appeals in accordance with Iowa Code section 35D.15.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 8417B, IAB 12/30/09, effective 2/3/10; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16; ARC 5800C, IAB 7/28/21, effective 9/1/21]

801—10.44 Reserved.

APPEAL PROCESS

801—10.45(35A,35D) Applicant appeal process. An applicant who believes that any of the provisions of this chapter have not been upheld, or have been upheld unfairly, may file an appeal directly with the commandant or designee containing a statement of the grievance and requested action. The commandant or designee shall investigate and may hold an informal hearing with the applicant and other involved individuals. Subrules 10.46(4) to 10.46(8) apply subsequently. The commandant or designee shall notify the applicant of the decision in writing within ten working days of receipt of the grievance.
[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter]

801—10.46(35A,35D) Member appeal process. A member who believes that any of the provisions of 801—Chapter 10 have not been upheld or have been upheld unfairly may file an appeal.

10.46(1) A member shall discuss the problem and action desired with the assigned social worker within five working days of the incident which caused the problem. The social worker shall investigate the situation and attempt to resolve the problem within five working days of the discussion with the member. If the assigned social worker has allegedly caused the grievance, the member may file the grievance directly with the social work supervisor.

10.46(2) If unable to resolve the problem, or if the member is dissatisfied with the solution, the social worker shall assist the member with filing a formal grievance and shall submit a report of the facts and recommendations to the administrator of nursing within five working days of the discussion with the member. The administrator of nursing shall inform the member of the decision in writing within five working days of receipt of the social worker's report.

10.46(3) If the member is not satisfied with the decision of the administrator of nursing, or if no decision is given within the time specified in subrule 10.46(2), the member may appeal to the commandant or designee within ten working days of the decision of the administrator of nursing or, if no decision is given, within ten working days of the time limit specified in subrule 10.46(2). The grievance shall be submitted in writing and contain a statement of the cause of the grievance and requested action. A copy of the decision of the administrator of nursing shall be attached to the grievance statement, if applicable. The commandant or designee shall investigate the grievance and may hold an informal hearing with the member, administrator of nursing, and other involved individuals. The commandant or designee shall notify the member and the administrator of nursing of the decision in writing within ten working days of receipt of the grievance.

10.46(4) If the member is not satisfied with the decision of the commandant, or if no decision is given within the time limits specified in subrule 10.46(3), the member may appeal to the commission within ten working days of the commandant's decision. The member and commandant shall be notified in writing within five working days of the commission's receipt of the appeal. The commission shall schedule a hearing with the member, commandant, and other involved individuals to determine the facts and make a final decision.

10.46(5) The member may appoint any individual to represent the member in the appeal process, at the member's expense.

10.46(6) No reprisals of any kind shall be taken against a member for filing an appeal.

10.46(7) The member may obtain judicial review of the commission's final decision in accordance with Iowa Code chapter 17A.

10.46(8) The time limits specified in the above subrules may be extended when mutually agreed upon by the persons involved in the appeal process.

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

Rules 801—10.45(35A,35D) and 801—10.46(35A,35D) are intended to implement Iowa Code subsection 35A.3(4) and Iowa Code chapter 35D.

801—10.47(35D) Involuntary discharge appeal. When a member appeals an involuntary discharge, the following provisions shall apply:

10.47(1) The member shall file the appeal with the commission within 5 calendar days of receipt of the discharge notice.

10.47(2) The commission shall conduct a contested case proceeding in accordance with the uniform rules on contested case proceedings found in 801—Chapter 8. The rules in 801—Chapter 8 are adopted by reference with the following amendment: The presiding officer must be a member of the commission and cannot be an administrative law judge with the department of inspections and appeals.

10.47(3) The commission shall render a decision on the appeal and notify the member of the decision in writing within 10 calendar days of the filing of the appeal.

10.47(4) If the member is not satisfied with the decision of the commission, the member may appeal the commission's decision by filing an appeal with the department of inspections and appeals within 5 calendar days of being notified in writing of the commission's decision.

10.47(5) The department of inspections and appeals shall render a decision on the appeal of the commission's decision and notify the member of the decision in writing within 15 calendar days of the filing of the appeal with the department.

10.47(6) The maximum time period that shall elapse between receipt by the member of the discharge notice and actual discharge shall not exceed 55 days which includes the 30-day discharge notice period and any time during which any appeals to the commission or the department of inspections and appeals are pending.

10.47(7) If a member is not satisfied with the decision of the department of inspections and appeals, the member may seek judicial review in accordance with Iowa Code chapter 17A. A member's discharge under rule 801—10.43(35D) shall not be stayed while judicial review is pending.

[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 8417B, IAB 12/30/09, effective 2/3/10; ARC 8635B, IAB 3/24/10, effective 4/28/10]

801—10.48 Reserved.

801—10.49(35D) Licensed nursing home administrator. The commandant shall employ a licensed nursing home administrator and convey the authority for compliance with all applicable laws and rules.

This rule is intended to implement Iowa Code chapter 135C.

[ARC 2675C, IAB 8/17/16, effective 9/21/16]

GROUPS AND FACILITY ADMINISTRATION

801—10.50(35D) Visitors. Visitors are welcome to IVH subject to the following conditions:

10.50(1) Member visitation hours are from 8 a.m. to 11 p.m. daily. Visiting hours may be extended on an individual basis with the approval of the commandant or designee.

10.50(2) Visitors are subject to the policies and procedures as established by IVH, including the tobacco-free policy.

10.50(3) Tours of IVH may be arranged by contacting the commandant or designee.

10.50(4) Weapons, illegal substances or alcoholic beverages are not permitted on IVH grounds.

10.50(5) Any disruptive behavior on the part of a visitor shall result in modification, denial or termination of visiting privileges.

10.50(6) Trespass. Visitors shall not enter IVH grounds with the intent to commit a public offense, remain upon the grounds or in IVH buildings without justification after being notified or requested to abstain from entering, or to remove or vacate therefrom by any peace officer, magistrate, or public employee whose duty it is to supervise the use or maintenance of IVH and its grounds.

10.50(7) Any visitor violating any of the rules within this chapter may be restricted from IVH for a period of time to be determined by the commandant or designee.

10.50(8) Visitors who bring pets must comply with IVH rules regarding pet health and safety. Pets shall be kept on a leash while on IVH grounds.

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.51(35D) Mail. Rescinded ARC 2675C, IAB 8/17/16, effective 9/21/16.

801—10.52(35D) Interviews and statements.

10.52(1) Releases to the news media shall be the responsibility of the commandant or designee. Authority for dissemination and release of information shall be designated to other persons at the discretion of the commandant or designee.

10.52(2) Interviews of members within IVH by the news media or other outside groups are permitted only with prior consent of the member to be interviewed or the member's legal representative. At the request of the person or group who wishes to conduct an interview, the commandant or designee shall seek to obtain the required consent from the member or the member's legal representative.
[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter]

801—10.53(35D) Donations. Donations of money, new clothing, books, games, recreational equipment or other gifts shall be made directly to the commandant or designee. The commandant or designee shall evaluate the donation in terms of the nature of the contribution to the facility program. The commandant or designee shall be responsible for accepting the donation and reporting the gift to the commission. All monetary gifts shall be acknowledged in writing to the donor and reported to the Iowa ethics and campaign disclosure board.

[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.54(35D) Photographing and recording of members and use of cameras.

10.54(1) Photographs and recordings of members within IVH by news media or other outside groups are permitted only with prior consent of the member to be photographed or recorded, or the member's legal representative. At the request of the person or group who wishes to make photographs or recordings, the commandant or designee shall seek to obtain the required consent from the member or the member's legal representative.

10.54(2) Every effort shall be made to preserve the inherent dignity of the member and to preclude exploitation or embarrassment of the member or the family of the member.
[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter]

801—10.55(35D) Use of grounds and facilities.

10.55(1) Persons wishing to use the facilities and grounds for civic purposes, programs for members, meetings, and similar purposes, must contact the commandant or designee at least two weeks in advance of the requested date. The commandant or designee may disapprove a request when the requested facilities are scheduled for use by or for the members, or when the activity would disrupt the normal operation of IVH. Previous arrangements to use the facilities or grounds may be canceled by the commandant or designee in the event of an emergency or when changes in the schedule require the use of the facilities or grounds for the members. Persons who use the facilities or grounds shall be held responsible for leaving the facilities or grounds in satisfactory condition and for any damages caused by or resulting from use.

10.55(2) Outside organizations permitted to use facilities or grounds shall observe the same rules as visitors to the facility.
[ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter]

801—10.56(35D) Nonmember use of cottages. Cottages may be made available to IVH staff or to other members of the public with the commandant's or designee's approval and at the established rate.

10.56(1) Expenses incurred as a result of damage or need for exceptional cleaning/sanitizing procedures, or both, may result in additional charges as determined by IVH.

10.56(2) Posted occupancy capacities shall not be exceeded and may be grounds for denial of use.

10.56(3) Pets are only allowed inside the cottages as outlined in the IVH cottage occupancy policy.
[ARC 8014B, IAB 7/29/09, effective 7/10/09; ARC 9689B, IAB 8/24/11, effective 9/28/11; ARC 1157C, IAB 10/30/13, effective 12/4/13; see Delay note at end of chapter; ARC 2675C, IAB 8/17/16, effective 9/21/16]

801—10.57(35D) Operating motor vehicles on grounds.

10.57(1) The operator of a motor vehicle shall have a valid license for the type of vehicle being driven upon IVH grounds.

10.57(2) All persons operating a motor vehicle on IVH grounds shall comply with the applicable state and local laws and IVH policies.

10.57(3) No driver of a motor vehicle or motorcycle shall disobey the instructions of any traffic-control device, warning, or sign placed.

10.57(4) No person shall drive any vehicle in such a manner as to indicate either a willful or wanton disregard for the safety of person or property. The person operating the motor vehicle or motorcycle shall have same under control and shall reduce the speed to 20 miles per hour on IVH grounds and reduce the speed to a lower, reasonable rate when approaching and passing a person walking in the traveled portion of a street.

10.57(5) No person shall stop, park, or leave standing any type vehicle in established fire lanes, emergency vehicle areas, and other essential lanes. No person shall park any type vehicle on roadways.

10.57(6) No person shall leave any type vehicle unattended by not locking doors or removing keys.

10.57(7) Failure to comply with rules may cause limitation or curtailment of driving privileges on IVH grounds for an indefinite period.

10.57(8) Motor vehicles belonging to members may be parked in member-designated parking on IVH grounds.

This chapter is intended to implement Iowa Code subsection 35A.3(4) and chapter 35D.

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¹ December 4, 2013, effective date of ARC 1157C [amendments to ch 10] delayed 70 days by the Administrative Rules Review Committee at its meeting held November 8, 2013. At its meeting held December 10, 2013, the Committee lifted the delay, effective December 11, 2013.

CHAPTER 14
VETERANS TRUST FUND

801—14.1(35A) Purpose. These rules establish the requirements for veterans or their spouses or dependents to receive benefits from the veterans trust fund.

801—14.2(35A) Definition. For purposes of this chapter, “veteran” means the same as defined in Iowa Code section 35.1 and federal VA regulations; a resident of Iowa who served in the armed forces of the United States, completed a minimum aggregate of 90 days of active federal service, other than training, and was discharged under honorable conditions; or a former member of the national guard, reserve, or regular component of the armed forces of the United States who was honorably discharged due to injuries incurred while on active federal service that precluded completion of a minimum aggregate of 90 days of active federal service, other than training.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 5812C, IAB 7/28/21, effective 9/1/21]

801—14.3(35A) Eligibility. Veterans, their spouses, and their dependents applying for benefits available under subrules 14.4(1) through 14.4(9) must meet the following threshold requirements.

14.3(1) Income. For the purposes of this chapter, an applicant’s household income, including VA pension benefits, service-connected disability income, and social security income, shall not exceed 300 percent of the federal poverty guidelines for the number of family members living in the primary residence in effect on the date the application is received by the county director of veterans affairs. Federal poverty guidelines shall be those guidelines established by the Iowa department of human services for the veteran’s family size. The commission shall adjust the guidelines on July 1 of each year to reflect the most recent federal poverty guidelines. The commission may waive the income threshold if all income is from a fixed source and all other sources of assistance have been exhausted.

14.3(2) Resources. For the purposes of this chapter, “available liquid assets” means cash on hand, cash in a checking or savings account, stocks, bonds, certificates of deposit, treasury bills, money market funds and other liquid investments owned individually or jointly by the applicant and the applicant’s spouse, unless the applicant and spouse are separated or are in the process of obtaining a divorce, but does not include funds deposited in IRAs, Keogh plans or deferred compensation plans, unless the veteran is eligible to withdraw such funds without incurring a penalty. Cash surrender value of life insurance policies, real property, established burial account, or a personal vehicle shall not be included as available liquid assets.

14.3(3) Funding from other sources. Applications shall not be approved if the applicant is eligible to receive aid from other sources to meet the purposes authorized in this chapter.

14.3(4) Additional requirements and limitations. Applicants must meet any additional requirements and are subject to any limitations which may be set out in this chapter or which may be established for a particular benefit.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 0057C, IAB 4/4/12, effective 5/9/12; ARC 5812C, IAB 7/28/21, effective 9/1/21]

801—14.4(35A) Benefits available. Applications may be approved for any of the following purposes. By a majority vote, the commission may suspend some or all of these benefits for payment.

14.4(1) Travel expenses for wounded veterans, their spouses and their dependents, directly related to medical care. Travel expenses under this subrule include the unreimbursed cost of airfare, lodging, and a per diem of \$50 per day for required medical appointments from the veteran’s home. Spouses may be reimbursed for in-state lodging and a per diem of \$50 per day when visiting a veteran who is in a hospital for medical care related to an injury or disability. The veteran or the veteran’s spouse shall provide such evidence as the commission may require, which includes but is not limited to evidence the injury or disability is service-connected, the necessity of treatment in a particular facility, and documentation of expenses. The maximum amount for travel expense reimbursement shall be \$90. The maximum amount of aid payable in a consecutive 12-month period under this subrule is \$1,000.

14.4(2) Job training or college tuition assistance for job retraining.

a. The commission may pay a veteran not more than \$5,000 for retraining or postsecondary education and Internet connection to enable the veteran to obtain gainful employment. The commission may provide aid under this subrule if all of the following apply:

(1) The veteran is enrolled in a training course in a technical college or school, is enrolled in an accredited postsecondary institution, or is engaged in a structured on-the-job training program.

(2) The veteran is unemployed, underemployed, or has received a notice of termination of employment.

(3) The commission determines that the veteran's proposed program, or current program, will provide retraining or initial training that could enable the veteran to find gainful employment. In making its determination, the commission shall consider whether the proposed program, or current program, provides adequate employment skills and is in an occupation for which favorable employment opportunities are anticipated.

(4) The veteran requesting aid has not received full reimbursement or payment from any other retraining or education scholarship programs and the veteran does not have other assets or income available to meet retraining or initial training expenses. Applicants requesting aid under this subrule will only be granted the unpaid portion of their tuition statement and a monthly Internet invoice. Payments will be made directly to the institution and Internet provider.

b. The veteran shall provide such evidence as the commission may require to satisfy the requirements of this subrule.

14.4(3) *Unemployment or underemployment assistance during a period of unemployment or underemployment due to prolonged physical or mental illness resulting from military service or disability resulting from military service (must be physically and mentally able to return to work).* The commission may provide subsistence payments only to a veteran who has suffered a loss of income due to prolonged physical or mental illness resulting from military service or disability resulting from military service. The commission may provide subsistence payments of up to \$500 per month of unemployment or underemployment to a veteran. A veteran must provide documentation of assistance from Iowa workforce development and vocational rehabilitation, if eligible. No payment may be made under this subrule if the veteran has other assets or income available to meet basic subsistence needs. A period of unemployment implies that it is possible for the veteran to be employed in the future. A rating from the VA of 100 percent due to individual unemployability (IU) rated permanent and total indicates that a veteran is unemployable and will not qualify for assistance under this subrule. The veteran shall provide such evidence as the commission may require, which includes but is not limited to evidence that the veteran is unemployed or underemployed for the period of payments. To qualify as underemployed, the applicant must be currently working at an income that is below 150 percent of federal poverty guidelines. The maximum amount of aid payable in a consecutive 12-month period under this subrule is \$3,000 and a lifetime maximum of \$6,000.

14.4(4) *Expenses related to hearing care, dental care, vision care, or prescription drugs.*

a. The commission may provide health care aid to a veteran, to the veteran's spouse or dependents, or to the unremarried spouse of a deceased veteran for dental care, including dentures; vision care, including eyeglass frames and lenses; hearing care, including hearing aids; and prescription drugs that are not covered by the veterans affairs medical center.

b. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$10,000 for dental care, \$500 for vision care, \$1,500 per ear for hearing care, and \$1,500 for prescription drugs and prescribed over-the-counter drugs. Lifetime maximum benefit: \$10,000 per eligible family member.

c. The commission shall not provide health care aid under this subrule unless the aid recipient's health care provider agrees to accept, as full payment for the health care provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. Payment under this subrule will be provided directly to the health care provider.

d. Applicants for assistance under this subrule will be required to provide the commission with an unpaid bill for service or an estimated cost of service from the health care provider and documentation of

the need for the service. For prescription drugs, the applicant must produce documentation of the need for the prescribed drug and documentation stating whether a generic drug is available or appropriate. The commission payment will not exceed an estimated cost of service by a health care provider.

14.4(5) *Expenses relating to the purchase of durable equipment or services to allow a veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home.*

a. The commission may make reimbursement payments to a veteran or to the unremarried spouse of a deceased veteran for the purchase of durable equipment that allows the veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home or allows them the ability to utilize more of their home.

b. Individuals requesting reimbursement under this subrule will be required to provide verification of the purchase and installation of the equipment and information relating to the need for the equipment. Individuals may also provide a product and installation cost estimate to the commission for approval, with the understanding that the commission will pay no more than the cost estimate to the supplier or installer. Applicants needing durable equipment as a medical necessity should provide information from a physician.

c. Assistance under this subrule cannot duplicate assistance from other entities, and the maximum amount that may be paid may not exceed \$5,000.

14.4(6) *Individual counseling or family counseling programs.*

a. The commission may make mental health, substance abuse, and family counseling available to veterans and their families. Individual family members are eligible for counseling.

b. The assistance may include appropriate counseling and treatment programs for veterans and their families in need of services.

c. Any assistance provided under this subrule shall not duplicate other services readily available to veterans and their families. Veterans who are eligible for VA mental health services must initially visit their nearest VA medical facility for initial consultation and continued psychiatric treatment. Payment under this subrule will be made for additional services for the veteran in a location closer to the veteran's home and at a greater frequency than the VA medical center can accommodate.

d. The commission may provide up to \$150 per hour and \$75 per half-hour for outpatient counseling visits to providers who will accept as full payment for the counseling services the amount provided. Counseling and substance abuse services provided in a group setting may be paid up to \$40 per hour. Counseling and substance abuse services may also be provided in an inpatient setting, subject to the maximum amount eligible under paragraph 14.4(6) "f."

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period shall not exceed \$5,000. Individuals seeking counseling services are eligible for up to \$2,500, individuals seeking substance abuse treatment and counseling combined are eligible for up to \$3,500, and families seeking counseling services that may also include individual counseling and substance abuse services are eligible for up to \$5,000.

f. The commission may not provide counseling under this subrule unless the aid recipient's counseling service provider agrees to accept, as full payment for the counseling services provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. The commission will make payment directly to the entity providing counseling and substance abuse services.

14.4(7) *Expenses relating to ambulance and emergency room services for veterans and emergency lodging for immediate family members.*

a. The commission may provide assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for emergency care patients or VA health care patients who cannot indicate to emergency personnel that they are to be presented to a VA medical center.

b. Funding through this subrule shall be paid directly to the entity providing the emergency service or transportation after the commission is provided with an unpaid bill. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this subrule.

c. The maximum amount that may be paid under this subrule may not exceed \$10,000.

14.4(8) *Emergency expenses related to vehicle repair or a one-time replacement vehicle, housing repair, or temporary housing assistance.*

a. The commission may provide assistance to a veteran or to the unremarried spouse of a deceased veteran for emergency vehicle repair, emergency housing repair, and temporary housing.

b. Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and from work-related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. Assistance may be provided in situations where the applicant does not have sufficient means to pay an insurance deductible. Assistance may be paid directly to the entity performing the maintenance or the insurance company owed the deductible. In certain circumstances, reimbursement may be made to the veteran or to the unremarried spouse of a deceased veteran in order for the vehicle to be released from the entity providing the service. Assistance will not be provided for damage caused during the commission of a crime, for cosmetic needs, for damage resulting in an auto accident when automobile insurance has not been purchased, or for routine maintenance. Vehicle replacement is a one-time use not exceeding \$5,000.

c. Assistance for home repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. Applicants with homeowners insurance may request assistance for payment of a deductible. Assistance may be provided for applicants in disaster situations, home accidents, vandalism, or other situations as determined by the commission. In situations where a home is damaged beyond repair, assistance under this subrule is available to assist the applicant in purchasing a new home.

d. Assistance for transitional housing may be provided to applicants who are displaced from their home during a period of repairs related to a disaster, vandalism, home accident, or other reason that makes staying in the home hazardous to the health of the residents. Any refunded security deposits paid for under this subrule shall be returned to the Iowa veterans trust fund.

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$1,000 for transitional housing. Lifetime maximum benefit for housing repair and vehicle repair: \$10,000 each.

14.4(9) *Expenses related to establishing whether a minor child is a dependent of a deceased veteran.*

a. The commission may provide assistance to the family of veterans who are killed while serving on active federal service, for expenses related to paternity or maternity tests or the cost of procuring additional DNA samples from the deceased veteran. This assistance is available to determine whether a child is eligible for United States Department of Veterans Affairs war orphan benefits.

b. Applicants are required to provide the results of the paternity or maternity examinations to the commission upon completion of the tests. Where the deceased veteran is not the parent of the child, the applicant will be required to repay the assistance received as provided in 801—14.6(35A).

c. The maximum amount that may be paid under this subrule is \$2,500.

d. The commission may waive the income threshold for this benefit.

14.4(10) *Family support group programs or programs for children of members of the military.*

a. The commission may award grants to unit family readiness/support groups, family support offices, and other such organizations providing support and programs to families and children of family members.

b. The grant shall be only for projects or programs which are not funded from any other source. The commission shall determine if the applicant's proposed project or program will provide the intended support. In making its determination, the commission shall consider whether the proposed program will provide anticipated favorable results.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a family readiness/support group is \$500.

14.4(11) *Honor guard services.*

a. The commission may reimburse veterans organizations for providing military funeral honors as follows:

(1) If a single veterans organization provides basic honors, \$25.
(2) If a single veterans organization provides full honors, \$50.
(3) If two or more veterans organizations participate in providing full honors and one of the organizations provides a firing detail, \$50. The organizations may request that the commission split the reimbursement.

(4) If two or more veterans organizations participate in providing basic honors, \$25. Payment shall be to one veterans organization, as determined by the commission.

b. Notwithstanding paragraph 14.4(11)“*a*,” the commission shall not reimburse a veterans organization if federal funding is available to reimburse the veterans organization for providing military funeral honors. The veterans organization shall request reimbursement from federal sources. If a veterans organization receives federal funding for providing military funeral honors at the reimbursement rate of one funeral per day, the department shall reimburse the organization for the provision of military funeral honors at any additional funerals on that day.

c. The maximum amount of aid payable in a calendar year under this subrule to a veterans organization is \$1,000.

d. Veterans service organizations that are not currently providing honor guard services may apply for a \$500 up-front grant for the use of creating a new honor guard within their organization. Applicants must present the commission with an estimated cost for purchasing uniforms and firearms for providing military honors and an estimated number of members who will be available to perform honor guard services. Organizations should also provide information regarding how they plan to pay for additional expenses that may occur outside of trust fund assistance. Applicants will be eligible for reimbursements under paragraphs 14.4(11)“*a*” to “*c*” 12 months after the receipt of their original \$500 grant.

14.4(12) Matching funds to veterans service organizations to provide for accredited veteran service officers. Rescinded IAB 11/6/19, effective 12/11/19.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 0057C, IAB 4/4/12, effective 5/9/12; ARC 2491C, IAB 4/13/16, effective 5/18/16; ARC 4105C, IAB 10/24/18, effective 11/28/18; ARC 4761C, IAB 11/6/19, effective 12/11/19; ARC 5012C, IAB 3/25/20, effective 4/29/20; ARC 5812C, IAB 7/28/21, effective 9/1/21]

801—14.5(35A) Application procedure. Applications for benefits from the veterans trust fund may be obtained at any county veterans affairs office. The county director of veterans affairs shall date-stamp the application and submit it to the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. 3465, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824.

14.5(1) Application process. A person who wishes to apply shall complete an Application for Veterans Trust Fund form and provide such documentation or other evidence as the commission may require in order to determine the awarding or denial of the benefits available under this chapter.

14.5(2) Date of application. The date of the application shall be the date the signed application and written verification are received by the Iowa department of veterans affairs.

14.5(3) Eligibility determination.

a. The county director of veterans affairs or members of the county commission shall make a recommendation to the Iowa commission of veterans affairs as to whether to approve or deny the application. The Iowa commission of veterans affairs or a subcommittee appointed by the chair shall approve or deny all applications. Applications submitted to the Iowa commission of veterans affairs will be processed at its quarterly meetings as set forth in 801—paragraph 1.2(2)“*a*” or during a conference call for the purpose of voting on a trust fund expenditure. Applications must be approved by a majority vote of the commission membership or appointed subcommittee. The director of the Iowa department of veterans affairs shall notify an applicant within 15 days of the commission’s decision. An explanation of the reasons for rejection of an application will accompany denials.

b. Applications for honor guard reimbursements under subrule 14.4(11) shall be processed solely by the Iowa department of veterans affairs and do not need commission approval for expenditure of trust fund interest balance funds for this purpose.

14.5(4) Waiting list. After all veterans trust fund moneys have been obligated, the commission shall approve or deny pending applications based on eligibility. Applicants who meet the eligibility requirements and are approved for payment by the commission shall be placed on a waiting list based

on the date of approval and then according to the order in which the completed applications and verification were received by the Iowa commission of veterans affairs. In the event that more than one application is received at one time, the applicant shall be entered on the waiting list on the basis of the applicant's birthday, the oldest applicant being first on the waiting list.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—14.6(35A) Recovery of erroneous payments.

14.6(1) *Erroneous payments.* The commission may recover payments made as a grant under this chapter if any of the following apply:

- a. The information provided by the applicant is inaccurate.
- b. The commission incorrectly calculated the grant amount.
- c. The applicant is not entitled to a grant or is entitled to a lower grant amount as a result of a change in circumstances that affects the applicant's eligibility to receive the grant.

14.6(2) *Amount of recovery.* The commission may recover only the portion of the grant to which the applicant would not have been entitled if the correct information had been provided or if the grant had been properly calculated or as a change in circumstances warrants.

14.6(3) *Remedies.* The commission may request repayment of the amount due under subrule 14.6(2). In lieu of a lump sum payment, the commission may enter into an agreement under which the applicant may repay the amount due within a 12-month period. If the applicant fails to repay the amount due within 30 days of a request for repayment or fails to comply with the terms of a repayment agreement, the commission may offset future grants that the applicant may be entitled to under this chapter until the amount due has been recovered. The commission may also suspend other benefits available to the applicant until the amount due has been recovered.

14.6(4) *Waiver.* The commission may temporarily or permanently waive its authority to recover payments under subrule 14.6(1) or suspend benefits under subrule 14.6(3) if the applicant's household income is totally exempt from Iowa garnishment law.

14.6(5) *Appeal.* Any commission decision under this chapter is subject to appeal under rule 801—14.7(35A).

801—14.7(35A) Appeal rights.

14.7(1) *Subcommittee action.* An applicant may appeal the decision of the subcommittee to the full Iowa commission of veterans affairs. The applicant shall appeal the decision of the subcommittee to the commission in writing within 30 days of receiving the written denial and shall provide relevant new information to substantiate the appeal.

14.7(2) *Final agency action.* The approval or denial of an application by the commission or by the department shall be the final decision of the agency.

14.7(3) *Judicial review.* Judicial review of the commission's or department's final decisions may be sought in accordance with Iowa Code section 17A.19.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 35A.13 as amended by 2007 Iowa Acts, House File 817, section 7.

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